

Release of Information Authorization

Patient Name: _____ Date of Birth: _____

Last 4 Digits of SSN: _____ Phone #: _____ e-mail address: _____

NOTE: All items, 1 through 6 must be completed, along with signature and date

1.) Release Records To: (Where do you want the information sent? Who may have the information?)	Name of individual, healthcare provider/hospital/practice: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Day Phone Number: _____ Fax Number: _____		
2.) Obtain Records From: (Who has the information you want released?) Please list the specific Hospital and / or clinic.	Name of Organization/Hospital or Medical Practice: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Day Phone Number: _____ Fax Number: _____		
3.) Release Instructions: (How do you want the information?)	Release Method / Format Requested: (check one) <input type="checkbox"/> Mail <input type="checkbox"/> My Chart / Epic <input type="checkbox"/> Fax (To healthcare provider ONLY) <input type="checkbox"/> Electronic <input type="checkbox"/> Other _____		
4.) Purpose of Release: (Why is it needed?)	<input type="checkbox"/> Continuing Care <input type="checkbox"/> Legal <input type="checkbox"/> Patient Request <input type="checkbox"/> Military <input type="checkbox"/> Insurance <input type="checkbox"/> Disability <input type="checkbox"/> School <input type="checkbox"/> Other _____ I understand that fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law.		
5.) Treatment Date(s): (When were you seen?)	<input type="checkbox"/> Treatment dates from _____ to _____ (please be specific) OR <input type="checkbox"/> All Treatment Dates		
6.) Information to be Released: (What do you want sent or released? Check the appropriate box.)	<input type="checkbox"/> Abstract Information History & Physical, Consults, Lab & Radiology Reports, Discharge Summary, Operative/ Procedure Reports, Emergency Department Reports, and Occupational / Physical Therapy Reports.	<input type="checkbox"/> Immunization Records <input type="checkbox"/> Medication List <input type="checkbox"/> Physician Progress / Visit Notes <input type="checkbox"/> Other: _____	<input type="checkbox"/> Psychotherapy <input type="checkbox"/> Test Results <input type="checkbox"/> Demographics
<p>I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, alcohol abuse, and/or results of tests for all infectious diseases including HIV / AIDS.</p> <p>I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked. This authorization will expire / end one year from the date of signature unless otherwise specified.</p> <p>I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving this information. I understand I have a right to a copy of this authorization.</p> <p>Proof of identity may be required, attaching a copy of your photo ID is recommended. (NOTE: Allow 30 days for processing according to Federal regulation.)</p> <p>Be aware the processing of this document will release the entire medical record requested which may include information from other providers.</p>			

Printed Name of Patient or Legal Guardian / Representative

Date

X _____
Signature of Patient or Legal Guardian Representative

Relationship to Patient, if Signed by Legal Guardian

Document(s) of patient representative's authority must be attached if patient is not signing.

When requesting Prisma Health to send records, return this form to:
 255 Enterprise Blvd., Suite 120, Greenville, S.C. 29615; Phone (864) 454-4600 Fax (864) 454-4654



Disclosure Med Info
Prisma Health-Upstate

Authorization for Disclosure of Medical Information

Patient Full Name (PRINT) _____ DOB _____ MRN _____

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Check and complete one)

YES - The provider may discuss my medical condition with the following family member or other individual:

NO The provider may not discuss my medical condition with any family member or other individual.

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Communication: Please provide phone number(s) where we can reach you (by providing a number you also authorize Prisma Health to leave you voicemails at the number(s) listed):

Home: _____ Cell: _____ Work: _____

Note: *An automated appointment reminder system may call the number listed in our data base.*

Signature: I hereby authorize the disclosure of my medical information as described above.

Patient/Patient's Representative Signature: _____ Date: _____ Time: _____

PRINT Name (if Patient's Representative): _____

Relationship to Patient (if Patient's Representative): _____

Prisma Health Representative: _____ Date: _____ Time: _____



Financial Policy

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided to the patient by Prisma Health and the various entities and providers affiliated with them each individually and collectively referred to as Prisma Health.

Payment for Service: Each office will inform you of co-pay and deductible amounts at check in or check out. These amounts are due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A \$25.00 service charge will be added on all checks returned to us for insufficient funds.

Non-appointment Prescription Refills: A \$15.00 charge per incidence may be added for non-appointment prescription refills.

Non-appointment Prescription: A \$25.00 charge may be billed to you for new prescriptions filled via phone.

Completion of Medical Forms: There may be a charge for completion of forms such as disability, camp physicals, etc.

Copies of Medical Records: There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities

- \$.65 per page for the first 30 pages
- \$.50 per page for all other pages
- Clerical fee not to exceed \$25.00
- Plus actual postage

No-show Appointments: A fee of \$25.00 for a follow up visit and \$50.00 for a new patient visit or endoscopy procedure may be charged for all missed appointments not canceled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling during normal office hours.

Payment for Services Provided by Certain Providers: If you are having laboratory and/or diagnostic services by providers other than this office or other practices doing business as Prisma Health University Medical Group, you may be billed separately by that service provider. This includes services provided by Prisma Health.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at 864-454-2000 or 1-888-284-6024 to make payment arrangements. We will attempt to contact you by letter before your account is forwarded.

Questions: We are here to help should you have any questions regarding your statement or insurance.

Today's Date _____ Patient Name _____ DOB _____

Hospitalization & Surgical History - List all hospital admissions and operations you have had.

Reason for Hospitalization/Surgery	Year
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____
7 _____	_____
8 _____	_____
9 _____	_____
10 _____	_____

Yes No Did you have any problems with anesthesia? If yes, please describe.

Social History

Yes No Do you currently smoke or use other tobacco products? If yes, how many per day? _____

Yes No Have you smoked or used other tobacco products in the past? If yes, how many per day? _____
How many years since you last smoked? _____

Yes No Do you drink caffeinated beverages? If yes, what type, how often, how much? _____

Yes No Do you drink alcohol? If yes, what type, how often, how much? _____

Yes No Do you exercise regularly? If yes, what type? _____
How often and how long? _____

Family Medical History - Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters), state your relationship and their age at onset.

	Relationship	Age at onset
<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> High Cholesterol	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Migraines	_____	_____
<input type="checkbox"/> Seizures/Convulsions	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Bleeding/Blood-clotting Disorder	_____	_____
<input type="checkbox"/> Allergies	_____	_____
<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Thyroid Problems	_____	_____
<input type="checkbox"/> Osteoporosis	_____	_____
<input type="checkbox"/> Psychiatric Disorder/Mental Illness	_____	_____
<input type="checkbox"/> Alzheimer's/Dementia	_____	_____
<input type="checkbox"/> Cancer - type:	_____	_____
<input type="checkbox"/> Other:	_____	_____



Medications Allergies and Immunizations

Today's Date _____ Patient Name _____ DOB _____

Please Bring All Medications to Your Visit

Prescription Medications -List all medications you are presently taking

Name and Dose	Prescribed by:	How Often	Date Started
1 _____			
2 _____			
3 _____			
4 _____			
5 _____			
6 _____			
7 _____			
8 _____			
9 _____			
10 _____			
11 _____			
12 _____			

Non-Prescription Medications -List all medications you are presently taking

Name and Dose	How Often	Date Started
1 _____		
2 _____		
3 _____		
4 _____		
5 _____		
6 _____		
7 _____		
8 _____		
9 _____		
10 _____		
11 _____		
12 _____		

Current Pharmacy

Name and Location _____ Phone Number _____

Preferred _____

Other _____

Today's Date _____ Patient Name _____ DOB _____

Allergies - list all allergies or unusual reactions you have to medications, foods, dyes latex and other agents.

Allergy	Reaction
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

List any reactions to bug bites or stings _____

Sexual Activity

Are you sexually active? Yes No

If you are sexually active, is your partner Male or Female?

Do you use birth control? Yes No If yes, what method? _____

Adult Immunizations - Check the box next to or list all immunizations received including the most recent date received.

	Date Received	Others	Date Received
<input type="checkbox"/> Tetanus	_____	_____	_____
<input type="checkbox"/> Flu	_____	_____	_____
<input type="checkbox"/> Pneumonia	_____	_____	_____
<input type="checkbox"/> HPV	_____	_____	_____
<input type="checkbox"/> Hepatitis B	_____	_____	_____

Screenings - List the most recent date and doctor for the following screenings:

	Date	Doctor/Practice/Facility Name
Complete Medical Physical	_____	_____
Full panel of lab work	_____	_____
Cholesterol (lipid) screening	_____	_____
Chest X-ray	_____	_____
Treadmill Stress Test	_____	_____
Other heart tests	_____	_____
Colonoscopy	_____	_____
Mammogram	_____	_____
Bone Density	_____	_____
	_____	_____
	_____	_____