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:____