Authorization

(updated October 2014)

This authorization form permits:

ADULT MEDICINE SPECIALISTS OF EASLEY PA

764 SACO LOWELL RD EASLEY SC 29640

to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ Birth Date _____

Address _____

City/State/Zip _____

Receiving Entity: Please check the boxes for the entities or persons you wish to get the described information about you.	Description to be given to checked entity or Person.
Voicemail Home # _____	☐ appointment time ☐ results of lab test or x-rays ☐ other _____
Voicemail Business # _____	☐ appointment time ☐ results of lab test or x-rays ☐ other _____
Voicemail Cell phone # _____	☐ appointment time ☐ results of lab test or x-rays ☐ other _____
Employer _____	☐ appointment or absentee information
School _____	☐ return to work or school information
Spouse (Provide name) _____	☐ Family billing information ☐ Financial information ☐ Medical information. Please list: _____
Parent (Provide name) _____	☐ Financial information ☐ Medical information. Please list: _____
Other (Provide name) _____relationship: _____	☐ Financial information ☐ Medical information. Please list: _____
Other (Provide name) _____relationship: _____	☐ Financial information ☐ Medical information. Please list: _____
Secure Patient Portal	☐ appointment information ☐ Medication/diagnosis information ☐ Message from office

Purpose: The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforced until revoked by the patient.

Verification method or mode: This practice will verify the identity of any entity requesting protected health information. Verification information may include:

_____PATIENT'S DATE OF BIRTH_____

Rights of the Patient:

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form.

I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ Date:_____

Signature of Patient or Personal Representative (as defined by HIPPA)

Description of Personal Representative's Authority (attach necessary documentation.)