Sandhills Medical Foundation, Inc.

WELCOME LETTER

Service Sites:

☐ ***BETHUNE***

103 Main St, South
Bethune, SC 29009
Telephone 843-334-7145
FAX 843-334-7141

☐ ***CAMDEN***

2611 Liberty Hill Rd, Suite B
Camden, SC 29020
Telephone 803-432-3447
FAX 803-432-3653

☐ ***JEFFERSON***

409 E. Church Street
Jefferson, SC 29718
Toll-Free 833-658-3005
FAX 843-658-7780

☐ ***KERSHAW***

205 W. Marion Street
Kershaw, SC 29067
Toll-Free 833-475-4701
FAX 803-475-4712

☐ ***LUGOFF***

40 Baldwin Avenue
Lugoff SC 29078
Telephone 803-408-3262
FAX 803-408-8835

☐ ***MCBEE***

645 South 7th Street
Post Office Box 366
McBee, SC 29101
Toll-free 833-335-8291
FAX 843-335-8731

☐ ***PAGELAND***

126 North Pearl St
Pageland, SC 29728
Telephone 843-675-5004
FAX 843-675-5005

☐ ***RUBY***

290 Market Street
Ruby, SC 29741
Toll-free 833-634-6044
FAX 843-634-6600

☐ ***SUMTER***

30 Cuttino Road
Sumter, SC 29151
Telephone 803-778-2442
FAX 803-778-0880

The staff at **Sandhills Medical Foundation, Inc. (SMF)** would like to take this opportunity to thank you for choosing us as your medical home. As your provider of health care, we look forward to serving you. We hope together, we can build a relationship that will ensure you receive the highest quality care and service. At SMF we believe it is very important that you know the benefits of receiving care from a patient centered medical home and encourage you ask our courteous staff if you have any questions.

A PATIENT CENTERED MEDICAL HOME IS ABOUT YOU

Caring about YOU is the most important job of a patient centered medical home. The care at an SMF patient centered medical home is personal, and the team's job is to manage your healthcare and medical needs. You can help us by always telling your medical home team if you get care from other health professionals and by providing us with updated insurance cards, phone number(s), and mailing address so we can help coordinate the best care possible.

These team members will help you get healthy, stay healthy, and get the care and services that are right for you. Your family caregivers are also part of the team, and YOU are the most important member!

NO SHOW, CANCELLATION, LATE ARRIVAL POLICY

We understand that there are emergencies and you may need to cancel or reschedule your appointment. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). If you have **two** "No-Show" appointments within a calendar year, you will receive a warning letter and if you have **three** "No-Show" appointments, you will no longer be able to schedule appointments for the remainder of the year. You will only be seen for Same Day and Walk-in appointments (pending availability).

If you arrive more than 15 minutes after your scheduled appointment you will be given the opportunity to wait as the schedule allows or an option to reschedule the appointment.

IMPORTANT CONTACT INFORMATION

As your patient centered medical home your care team is available 24/7. If you need care afterhours, you can communicate with your care team afterhours by phone, to contact a Provider after office hours, please call our on-call service at (803) 401-5966 or call **911** for emergencies.

We thank you for taking the time to read and understand the information included in our Welcome Letter. If you have further questions, please do not hesitate to ask as staff member.

PATIENT RIGHTS & EXPECTATIONS

- ✓ This health center was created to serve the needs of your community. Persons represent you on the Board of Directors in your community. We want YOU to be an active part of your treatment here.
  That means you have to know what you can expect from us. You need to know what your rights are. We want you to be informed about our policies regarding confidentiality, treatment of minors, and other critical issues. There are some situations, however, when the law itself determines what we must do.
- ✓ You have the right to receive appropriate care, regardless of race, creed, color, national origin, religion, sex, age, handicap, and ability to pay.
- ✓ You have a right to participate in your care; it helps to create a successful outcome.
- ✓ You have a right to confidential treatment. You also have the right to approve or disapprove the release of any disclosures or records, except when release is required by law.
- ✓ You have a right to information about your diagnoses treatments and prognosis. We expect this information will help you to make informed decisions regarding your medical care.
- ✓ You have the right and expected to participate in decisions about the intensity and scope of your treatment, within the limits of the health center's mission and applicable laws.
- ✓ You have a right to care, which takes into consideration your psychosocial, spiritual, and cultural values.
- ✓ You have the right to accept medical care or to refuse treatment, to the extent permitted by law. You also have the right to be informed of the medical consequences of refusing treatment.
- ✓ You have the right to participate in the consideration of ethical issues that arise in your care.
- ✓ Your guardian, next of kin, or legally authorized responsible person can exercise your rights for you if you have been medically or legally determined to be unable to participate yourself.
- ✓ You have the right to be informed of any research or experimentation which could affect your care. You may then decide whether or not you want to participate in it.
- ✓ You have the right to be made aware of advanced directives, and to know how this organization will respond to such advanced directives.

If you feel your rights have been violated, please contact our Director Compliance at 1-800-763-6384

PATIENT REPONSIBILITIES

You also have responsibilities that are an equally important part of providing quality health care.

- ✓ You are responsible for following center rules and regulations affecting patient care and conduct.
- ✓ You are responsible for providing, to the best of your ability, a complete and accurate medical history.
- ✓ You are responsible for making it known whether you clearly understand a plan of action and the things you are expected to do.
- ✓ You are responsible to be considerate of the rights of other patients, center personnel and the treatment of center property.
- ✓ You are responsible for providing the center with accurate and timely information concerning your income and for meeting your financial responsibilities to the best of your ability.
- ✓ You should allow **three (3) business days** for all **REFILL REQUESTS** not made during an office visit. Contact your pharmacy to see if your prescription is ready.
- ✓ You should allow **ten (10) business days** for all **DOCUMENTS or FORMS** that need to be completed. This also includes forms for a handicap plate and FMLA (Family Medical Leave Act). Some forms or documents may require an office visit. You will be contacted if the Provider finds it necessary to make an appointment.
- ✓ You should allow **seven (7) business days** to receive **LAB or IMAGING RESULTS** that are not discussed during a scheduled office visit. You may be notified by phone or mail if results are not discussed in the office. Please make sure the Front Desk Staff has the **ACTIVE** phone number and address that is best to reach you for your results. (You can also access your results in your patient portal. Make sure we have your email address.)
- ✓ You should allow **two (2) business days** for Nursing Staff to return any **MESSAGES** left on the **VOICEMAIL**. DO **NOT** leave **URGENT** messages on the voicemail. If you think, you need to see a provider, call the office, and ask the Front Desk Staff to make you an appointment.
- ✓ You should allow **ten (10) business days** for **REFERRALS** completed on your behalf. You will be notified by phone and/or mail of your appointment time and date. Please make sure the Front Desk has an **ACTIVE** phone number and address that is best to reach you for your appointment.

If you have any questions about your Rights and Responsibilities as a patient of SMF, you can ask any staff member.

Sandhills Medical Foundation, Inc.

PATIENT INFORMATION

Patient Demographics

Patient Demographics (Please provide an acceptable picture ID)

First/MI/Last Name:	Date of Birth:	Age:

Mailing Address:	Apt #	Social Security:

City/State/Zip Code:

Cell Phone:	Home Phone:

Email Address (Required for Patient Portal Online Services):

Select all methods that a message can be delivered: ☐ Leave Message ☐ Text ☐ Email

Emergency Contact:	Phone Number:	Relation to Patient:

Employment Information

Employer Name:	Phone Number:	Migrant/Seasonal worker? ☐ Yes ☐ No

Employment Status: (please select one)
☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed

Are you a Student? (please select one):
☐ Full-Time ☐ Part-Time ☐ No ☐ Decline

Total Household Yearly Income:
☐ <10,000 ☐ 20,000 ☐ 30,000 ☐ 40,000 ☐ 50,000 ☐ 60,000 ☐ >70,000

Total Number of People Living in Household:

Pediatric Guardian

If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Guardian First/Last Name:	Phone Number:

Date of Birth:	Social Security:	Relationship to Patient:

Personal Information

By participating in federal programs, we are required to request the following information (please select the below)

Race:
- ☐ Black/African American
- ☐ White
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ More than one race
- ☐ Decline

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Mexican, Mexican American, Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic, Latino/a or Spanish origin
- ☐ Total Hispanic, Latino/a or Spanish origin
- ☐ Decline

Veteran?
☐ Yes ☐ No

Homeless?
☐ Yes ☐ No

Relationship Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow(er)

Gender Identity:
☐ Male ☐ Transgender Male(Female to Male) ☐ Other
☐ Female ☐ Transgender Male(Male to Female) ☐ Decline

Sexual Orientation:
☐ Straight or heterosexual ☐ Don't know ☐ Decline ☐ Bisexual
☐ Lesbian or Gay or homosexual ☐ Something else________________________

Insurance Information	**Insurance Information (Please provide all insurance cards)**	
	Federally Qualified Health Centers offer a Sliding Fee discount, would you like to see if you are eligible for a discount on your care? ☐ Yes ☐ No If yes, you must fill out the required forms and provide proof of income per the requirement of our grant funding. You will also be asked to make your nominal fee payment. We encourage all patients to apply for the discount program even if you have insurance.	
	Primary Insurance Plan (Please select one): ☐ Medicare ☐ Medicaid ☐ Other Insurance ☐ None	**Secondary Insurance Plan** (Please select one): ☐ Medicare ☐ Medicaid ☐ Other Insurance ☐ None
	Insurance Company Name:	Insurance Company Name:
	Policy Holder Name:	Policy Holder Name:
	Policy Number:	Policy Number:
	Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
	Policy Holder's Social Security:	Policy Holder's Social Security:
	Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Other	**Do you have an Advanced Directive?**	**Do you have a Primary Caregiver?** ☐ Yes ☐ No	
	☐ **Yes** ☐ **No**	Name:	
	If yes, please select all that apply: ☐ Do Not Resuscitate ☐ Living Will ☐ Medical Power of Attorney	Address:	
		Phone Number:	Relationship to Patient:

Sandhills Medical Foundation, Inc.

NO SHOW, LATE ARRIVAL AND CANCELLATION POLICY

Sandhills Medical Foundation, Inc. understands that there are emergencies and you may need to cancel or reschedule your appointment. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24 hour notice).

To ensure that each patient is given the proper amount of allotted time for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted three days prior to your scheduled appointment and a text reminder will also be sent two days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICIES:

1. Please cancel your appointment with at least a 24 hour notice: There is a waiting list to see the clinicians at Sandhills Medical Foundation, Inc. and whenever possible we like to fill cancelled appointments to shorten the waiting period for our patients.
2. If less than a 24 hour notice is provided for cancellation, this appointment will then be documented as a “No Show” appointment.
3. If you do not arrive at the office for your scheduled appointment time, this appointment will be documented as a “No Show” appointment.
4. If you have two “No Show” appointments within a calendar year, you will receive a warning letter from Sandhills Medical Foundation, Inc.
5. If you have three “No Show” appointments within a calendar year, you will no longer be able to schedule appointments for the remainder of the year. You will only be seen for Same Day and Walk-in appointments (pending availability).
6. If you arrive more than 15 minutes after your scheduled appointment you will be given the opportunity to wait as the schedule allows or an option to reschedule the appointment.

   I understand Sandhills Medical Foundation’s No Show, Late Arrival, and Cancellation Policies and understand my responsibility to plan appointments accordingly and notify Sandhills Medical Foundation, Inc. appropriately if I have difficulty keeping my scheduled appointment or arriving on time.

______________________________________ ______________________

Patient Name Date of Birth

______________________________________ ______________________

Patient Signature Date

Sandhills Medical Foundation, Inc.

CONSENT FOR SERVICES AND CARE

PATIENT NAME: ______________________________ DATE OF BIRTH: _________________

GENERAL CONSENT TO CARE

I, the undersigned, for myself, minor child, or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care/treatment is provided at any office managed by SMF. This consent includes all medical/behavioral services, diagnostic procedures and treatment rendered under the general or specific instructions of a SMF provider, attending or referral physician, including: ordered exams, X-ray procedures, laboratory test, EKG's, treatment/medication, monitoring, and/or any other tests/procedures deemed necessary. HIV and Hepatitis C will be screened annually for persons 18 years or older unless I opt out. I understand that, as a patient, I am under the direct care of physicians and that the employees, agents and representatives of SMF will carry out the instructions of those physicians. I further understand that SMF does not control the decisions or actions of physicians who provide treatment to me, whether members of the medical center's staff or independent contractors. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations at SMF facilities.

MEDICAL RESIDENT AND CLINICAL STUDENT PARTICIPATION

I understand that SMF has educational affiliations with medical schools and other educational institutions and I consent/agree to a medical resident and/or clinical student participating in my care under appropriate supervision.

RELEASE OF INFORMATION FOR BILLING PURPOSES

I hereby acknowledge and agree that SMF and all providers participating in my treatment may release to my insurers, other payers or other persons as necessary for billing and related purposes, at reasonable times and in accordance with SMF policies and procedures, any information which may be needed for the purpose of billing, collection or payment of claims for services provided at or by SMF. This information may include, but is not limited to, my identity, medical/psychological evaluations, diagnosis, prognosis and treatment for physical/emotional illness, developmental disabilities, surgical procedures, progress notes and all other information contained in patient care records to the extent that such records are needed for billing or collection of benefits due me from any payer. This authorization will terminate upon payment in full of all claims related to services provided by SMF to me or to the patient for whom I am signing. On an inpatient, outpatient or emergency department basis, I permit a copy of this authorization to be used in place of the original.

ASSIGNMENT OF INSURANCE BENEFITS

I/we authorize SMF to act in my/our behalf as attorney in fact: (1) in the collection of benefits from any responsible third party through whatever means may be deemed necessary, and (2) in the endorsement of benefit checks made payable to myself and/or SMF. I/we hereby authorize payment directly to assign to SMF and provider(s) any and all rights that the patient and I have or to which we may become entitled, under any policy of insurance or any employee welfare benefits plan governed by the Employee Retirement Income Security Act. I/we further warrant and represent that any insurance that we assign is not only a valid insurance, but also in effect, and that we have the right to make this assignment. If eligible for Medicare, I/we request Medicare services and benefits. I understand I am responsible for any charges not covered by insurance, Medicare, Medicaid and any other form of health or welfare benefit.

PAYMENT GUARANTEE

I understand that I am financially responsible to SMF. I expressly promise and agree to pay SMF all such charges which are not paid by my insurance plan, PPO, HMO or other coverage and any applicable co-payments and deductible charges for services that are not covered by the Medicaid or Medicare programs. I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions whereby coverage is subject to a coordination of benefits clause.

Should this account be turned over to a collection agency or to an attorney for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees.

By my signature, I understand and agree to the above statements:

_________________________________ _________________________________

Signature of Patient/Other (If other, state relationship to patient here)

_________________________________ _________________________________

Date Signed Witness

Sandhills Medical Foundation, Inc.

ABOUT OUR NOTICE OF PRIVACY PRACTICES

At Sandhills Medical Foundation, Inc., we are committed to protecting your personal health information in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Notice of Privacy Practices states:

- How we may use and/or disclose the health information that we keep about you.
- You rights relating to your personal health information.
- Our obligations under the law with respect to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in the Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give provide you with a copy of the Notice of Privacy Practices and to obtain your written acknowledgement that you have received a copy of this notice.

A copy of Notice of Privacy Practices and Patient Rights and Responsibilities is located in your New Patient packet, available upon request at the front desk and posted in the lobby of this facility.

Patient Acknowledgement of Receipt

I,_____________________________________, hereby acknowledge that I have received a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities.

_______________________________________ ______________________

Signature of Patient/Other Date

_______________________________________ ______________________

Signature of Parent or Patient's Representative Date

____

Description of Legal Authority to Act on Behalf of Patient

Sandhills Medical Foundation, Inc.

SOUTH CAROLINA HEALTH INFORMATION EXCHANGE(SCHIEx)

PATIENT NAME: ___________________________**DATE OF BIRTH**:__________________**LAST 4 SSN**________

SOUTH CAROLINA HEALTH INFORMATION EXCHANGE (SCHIEX) CONSENT OR OPT OUT FORM

Sandhills Medical Foundation, Inc. has become a member of the South Carolina Health Information Exchange ("SCHIEx"). Your privacy and your personal health information are protected by federal and state law. Those federal and state laws also govern the way your personal and electronic health information is used or shared through SCHIEx. Your doctors and your other health care providers will use and share your electronic health information with other doctors and health care providers, *involved in your care*, through SCHIEx EXCHANGE to provide, coordinate, or manage your health care and any related services.

SCHIEx EXCHANGE members may include health care providers licensed in the State of South Carolina, including medical doctors, dentists, chiropractors, optometrists, podiatrists, pharmacists, physician assistants, and nurse practitioners. Members also may include organizations such as hospitals, ambulatory surgical facilities, home health agencies, pharmacies, case management providers, tele-monitoring providers, health information exchanges and organizations within which eligible individuals practice. We may also share your personal health information through SCHIEx EXCHANGE with agencies that audit, investigate, and inspect health programs for the health and safety of the public. We may submit information as required by law, including but not limited to: immunization data, quality reporting data, and communicable disease data to a state or federal agency.

You are required to sign this form, acknowledging that you have received this SCHIEx Notice of Participation, and you agree to have your health information shared with other doctors and health care providers involved in your care.

Print Name____ **Signature**____

Today's Date________________________________

Opt Out

If you Opt Out today and change your mind tomorrow, next week, or even next year, talk to your doctor or a member of the staff about how to Cancel Your Opt Out so your health information may be shared through SCHIEx EXCHANGE with other doc-tors and health care providers involved in your care.

____**I do not** want my doctor or other health care providers to share my health information through SCHIEx EX-CHANGE. I understand that my electronic health information will not be shared for treatment, including in cases of emergency, through SCHIEx EXCHANGE.

Print Name____ **Signature**____

Today's Date________________________________

For Office Use only

Signature of Staff Member Executing Opt Out______________________________Date and Time Executed____________

Sandhills Medical Foundation, Inc.

SLIDING FEE ELIGIBILITY FORM

Location: ☐ **Camden** ☐ **Jefferson** ☐ **Kershaw** ☐ **Lugoff** ☐ **McBee** ☐ **Ruby** ☐ **Sumter** **Date:** ____________________

Patient Information

First/Last Name:	Social Security Number:
Mailing Address:	Date of Birth:
City/State/Zip Code:	☐ First time applicant ☐ Renewal
Primary Phone Number:	Other Phone:

Household Information

Household Information (Must be completed for all applicants)

Please list any additional members currently living in the household below:

Name:	DOB:	Total number of members living in your household:
Name:	DOB:	
Name:	DOB:	
Name:	DOB:	

Household Income Information

How frequently do you get paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

Please list the income for any additional members in the household that are over the age of 18:

Patient:	Spouse:
Children:	Other(s):

Company Name: ☐ Self Employed

Other Sources of Income:

☐ Social Security ☐ Income ☐ Rental Income ☐ Retirement Pension
☐ Public Assistance ☐ Interest ☐ Other________________________________

Acceptable proof of Income for the past 30 days must be provided within 14 days. Please provide two check stubs (if paid bi-weekly), four check stubs (if paid weekly), pension income, social security, or a written letter from your employer on company letterhead with address and phone number included. If self-employed the most recent year's tax return must be provided.

Gross Wages

Weekly Income:	X 52	Total:
Bi-Weekly Income:	X 26	Total:
Monthly Income:	X 12	Total:
Semi-Monthly Income:	X 24	Total:
Yearly Income:	X 1	Total:

Calculations

Office use only

I declare the above information is true and I have given Sandhills Medical Foundation, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist during my next visit to the clinic. I also understand I must recertify every 12 months.

Signature____ **Date**___________________ **Front Office Staff Initial**_____________

Sandhills Medical Foundation, Inc.

SLIDING FEE POLICY CERTIFICATION

Patient Name: (Please Print): ____

ALL SLIDING FEE APPLICANTS PLEASE READ AND SIGN THE FOLLOWING:

The policy concerning the sliding fee program reads that the applicant has to bring in their proof of income within 14 days. I understand that I need to provide an acceptable form of income proof for the past 30 days such as pay stubs, income tax return, social security, pension income, or a written letter from my employer on a company letter head with address and phone number included. If self-employed I must provide the most recent year's tax return. If I do not supply this information in the allotted time, I will have to submit both a new application along with the proof of income. No discounts will be given until this is complete, and discounts will not be given on visits prior to new application date.

I also understand that if my income should change that I am required to notify the receptionist during my next visit to Sandhills Medical Foundation, Inc. I also understand I must recertify every twelve months.

I also understand that I must inform Sandhills Medical Foundation, Inc. if I or anyone in my household becomes covered by any health insurance policy. Sandhills Medical Foundation, Inc. has my permission to bill any eligible insurance.

I, ____ understand the updated policy for all sliding fee applicants. I agree to comply with this policy.

______________________________________ ______________________

Signature Date

Sandhills Medical Foundation, Inc.

AUTHORIZATION TO OBTAIN/RELEASE PROTECTED HEALTH INFORMATION

Name of Patient______________________Date of Birth_____________SSN (last 4):_________Telephone #_________________

I authorize information to be released to or from:	TO: Sandhills Medical Foundation, Inc.	FAX TO:
_______________________________________ Name of Office/Provider/Person	○ 40 Baldwin Avenue, Lugoff, SC, 29078 Phone#: 803-408-3262	803-408-8895
	○ 645 S. 7th Street, McBee, SC, 29101 Phone#: 833-335-8291	843-335-8731
_______________________________________ PO Box or Street Address	○ 30 Cuttino Rd., Sumter, SC, 29151 Phone#: 803-778-2442	803-778-0880
	○ 409 E. Church Street, Jefferson, SC, 29718 Phone#: 833-658-3005	843-658-7780
_______________________________________ City, State, Zip Code	○ 2611 Liberty Hill Road, Camden, SC, 29020 Phone#: 803-432-3447	803-432-3653
	○ 205 W. Marion Street, Kershaw, SC, 29067 Phone#: 833-475-4701	803-475-4712
_______________ _______________ Phone Number Fax Number	○ 290 Market Street, Ruby, SC, 29741 Phone#: 833-634-6044	843-634-6600
	○ 103 Main St, South Bethune, SC 29009 Phone#: 843-334-7145	843-634-6600
○ Release to the patient named above	○ 126 N Pearl St, Pageland, SC 29728 Phone#: 843-675-5004	843-675-5005

Information to be Released:

○ All medical records (Records are limited to the last 2 years of information unless otherwise specified)

○ Emergency room report ○ Radiology reports ○ Prenatal records ○ School physical form

○ Immunizations/shot records ○ Consultation report ○ Laboratory reports ○ Discharge summary

○ Billing records ○ COVID-19 Test Results ○ Other (Please specify)____________________________

I specifically **PROHIBIT** the release of the following sensitive health information. I understand that for any of the following boxes that are not checked, the health information released to the named recipient may include diagnosis, evaluation and/or treatment information for the following:

○ HIV or AIDS testing information and/or results ○ Alcohol and/or substance abuse

○ Genetic Information and/or test results ○ Mental Health (Except psychotherapy notes)

Dates of Service Requested:

○ From_____________________to_____________________ ○ Most Recent ○ All records

Reason for Release:

○ Continuity of Care/Other Clinician ○ Patient Request ○ Other (Please specify)____________________________

Delivery Requested:

○ CD by mail ○ Electronic by secure message (e-mail) ○ Paper by mail

○ CD for pick-up ○ Paper for pick-up ○ Paper by fax

I understand that this authorization is subject to revocation/withdrawl by me at any time in writing to the Chief Compliance Officer at 1111 Broad Street Suite 3C, Camden SC 29020, except to the extent that action has already been taken to release this information.

I understand that this authorization is vouluntary and I may refuse to sign this authorization. The above named person/institution will not refuse to treat me based on whether I allowmy health information to be used and disclosed by others.

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Expiration Date: This authorization shall remain valid unless revoked but will expire **one (1) year** from the date of my signature or as otherwise specified by the date, event, or condition(s) as follows:

____ _________________________

Signature of Patient Date

____ _________________________

Signature of Parent/Legal Guardian or Representative Relationship to Patient

(Required if patient is not legally authorized to sign authorization)

Authorization must be written, dated, and signed by patient or by person authorized by law to give authorization.