Carolina Geriatric Specialists, LLC
Geriatric Medicine
244 Church Street
Sumter, SC 29150
803-775-1001

PATIENT NAME: _____ DATE OF BIRTH: _____

NOTICE OF PRIVACY PRACTICES RECEIPT

I ACKNOWLEDGE THAT I WAS PROVIDED WITH THE NOTICE OF PRIVACY PRACTICES OF CAROLINA GERIATRIC SPECIALISTS, LLC.

SIGNATURE: _____ DATE: _____

CONSENT FORM FOR RELEASE OF PATIENT INFORMATION TO ANOTHER PERSON OTHER THAN THE PATIENT.

CAROLINA GERIATRIC SPECIALISTS, LLC AT 244 CHURCH STREET, SUMTER, SC 29150 IS AUTHORIZED TO DISCLOSE PROTECTED HEALTH INFORMATION ON (PATIENT NAME) _____ TO THE ENTITIES NAMED BELOW. I (PATIENT NAME) _____ GIVE MY PERMISSION TO CAROLINA GERIATRIC SPECIALISTS, LLC OR ANY MEMBER OF ITS STAFF TO RELEASE OR OBTAIN ANY INFORMATION TO OR FROM ANY OTHER PHYSICIAN OR MEDICAL FACILITY, WHILE I AM UNDER CAROLINA GERIATRIC SPECIALISTS, LLC MEDICAL CARE. I ALSO GIVE MY PERMISSION TO CAROLINA GERIATRIC SPECIALISTS, LLC TO RELEASE ANY INFORMATION REGARDING MY MEDICAL CONDITION OR ACCOUNT INFORMATION TO THE BELOW LISTED PERSON/PERSONS IF I AM UNAVAILABLE. I RELEASE CAROLINA GERIATRIC SPECIALISTS, LLC FROM ANY LIABILITY REGARDING THE ABOVE STATEMENTS.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

***PLEASE INTITIAL AND MARK YES/NO TO FOLLOWING STATEMENT:**

_____ (INITIAL) circle: YES/NO LEAVE DETAILED INFORAMTION SUCH AS APPOINTMENTS, ACCOUNT INFORMATION AND/OR TESTING RESULTS ON MY OR THOSE ABOVE ENTITIES ANSWERING MACHINE OR VOICE MAIL.

PATIENT NAME: _____

*__PATIENT PORTAL__

_____ (INITIAL) circle: YES/NO WE MAY SEND AN ELECTRONIC COPY OF LABATORY FINDINGS, RADIOLOGY FINIDNG, AND CLINICAL SUMMARIES OF YOUR OFFICE VISITS TO YOU THROUGH THE FOLLOWING EMAIL: _____

USERNAME: (office use) _____ PASSWORD:_____

ALTERNATE #1

_____ (INITIAL) circle: YES/NO WE MAY SEND AN ELECTRONIC COPY OF LABATORY FINDINGS, RADIOLOGY FININGS, AND CLINICAL SUMMARIES OF YOUR OFFICE VISITS TO THE FOLLOWING PERSON _____ , relationship _____ @ THE FOLLOWING E-MAIL ADDRESS

_____.

USERNAME: (office use) _____ PASSWORD:_____

ALTERNATE#2

_____ (INITIAL) circle: YES/NO WE MAY SEND AN ELECTRONIC COPY OF LABATORY FINDINGS, RADIOLOGY FININGS, AND CLINICAL SUMMARIES OF YOUR OFFICE VISITS TO THE FOLLOWING PERSON _____ , relationship _____ @ THE FOLLOWING E-MAIL ADDRESS

_____.

USERNAME: (office use) _____ PASSWORD:_____

I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME AND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE DISCLOSED AS DESCRIBED IN THIS DOCUMENT. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE IN CASES WHERE THE INFORMATION HAS ALREADY BEEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____

RELATIONSHIP IF NOT PATIENT: _____DATE: _____

SIGNATURE OF WITNESS (OFFICE STAFF) _____ DATE: _____