244 Church Street, Sumter, SC 29150
(803)775-1001 Fax: (803)774-1012

PATIENT NAME: ____ DATE OF BIRTH: ____________________

NOTICE OF PRIVACY PRACTICES RECEIPT

I ACKNOWLEDGE THAT I WAS PROVIDED WITH THE NOTICE OF PRIVACY PRACTICES OF CAROLINA CONCIERGE CARE.

SIGNATURE: ____ DATE: ____________________________

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

CAROLINA CONCIERGE CARE 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 CONCIERGE CARE 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 CONCIERGE CARE MEDICAL CARE. I ALSO GIVE MY PERMISSION TO CAROLINA CONCIERGE CARE TO RELEASE ANY INFORMATION REGARDING MY MEDICAL CONDITION OR ACCOUNT INFORMATION TO THE BELOW LISTED PERSON/PERSONS IF I AM UNAVAILABLE. I RELEASE CAROLINA CONCIERGE CARE 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: ___________________