



DISCLOSURE OF MEDICAL INFORMATION

Patient Full Name (PRINT) \_\_\_\_\_ DOB \_\_\_\_\_

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals who we are authorized to discuss your care with. (NOTE: We can not discuss your care with others, including spouses or other family members living with you, unless they are listed below.)

Name of Person \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Confidential Communication: Communication between this practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

Home: \_\_\_\_\_ Work: \_\_\_\_\_
Cell phone: \_\_\_\_\_ Other: \_\_\_\_\_

If we are unsuccessful at reaching you at the above phone numbers, please list others who we can contact to get a message to you to call our office. An automated appointment reminder system will call your home number listed in our data base.

Name of Person \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Messages: A request for return calls may be left on the following answering machine or voice mail (check all that apply)

At home At work On my cell phone I do not authorize

I authorize any medical information regarding myself to be left on the following answering machine or voice mail (Check all that apply) At home At work On my cell phone I do not authorize

Signatures: I hereby authorize the use or disclosure of the personal health information as described above.

Patient/Personal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PRINT Name of Personal Representative: \_\_\_\_\_

Relationship of Representative to Patient: \_\_\_\_\_

GHS UMG Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Note: This restriction applies only to care provided by the Greenville Health System Practice identified in the upper left hand corner of this form. Other providers involved in your treatment may require you to complete a separate request for restriction. Either you or GHS may terminate this restriction by completing the following. The below signature is to be used if you would like to make the above information terminate on a certain date.

This agreement is terminated as of \_\_\_\_\_ Signature \_\_\_\_\_ (Date) \_\_\_\_\_