

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

## ONE PER REQUEST

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

is requesting that the Greenville Hospital System University Medical Group practice identified above release health information (check one)  TO or obtain  FROM the person/company/agency/facility listed below.

Name, Position, or Department:	_____
Name of Organization:	_____
Address of Organization:	_____
Phone number of Organization:	_____

The information to be disclosed relates to service dates beginning \_\_\_\_\_ and ending \_\_\_\_\_

<input type="checkbox"/> Entire medical record	<input type="checkbox"/> Medication List	<input type="checkbox"/> Physical Therapy notes
<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Occupational Health Record
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Test Results (lab, X-ray, etc.)	<input type="checkbox"/> Other: (specify)
<input type="checkbox"/> Medical/Surgical History	<input type="checkbox"/> Other Assessments	<input type="checkbox"/> Other: (specify)
<input type="checkbox"/> Physician Office Visits	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Other: (specify)

The purpose of the disclosure: (*"Request of the Individual" is sufficient for patient-initiated releases*)

<input type="checkbox"/> Request of Individual	<input type="checkbox"/> Change of Doctor	<input type="checkbox"/> Legal Investigation
<input type="checkbox"/> Referral to Specialist	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other: (specify)
<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Workers Comp	

### CONDITIONS and NOTIFICATIONS:

This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Supervisor at the address listed above. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to the GHS UMG group practice identified above and to GHS and each practice and entity affiliated with it including GHS Partners in Health.

**Note:** There may be a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

### SIGNATURES:

I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

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

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

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

Released by: _____ (Department Representative Name)	Date: _____
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**Greenville Hospital System  
University Medical Group\*  
Consent for Treatment**



**GREENVILLE  
HEALTH SYSTEM**

The following are the conditions for services provided by Greenville Hospital System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Hospital System University Medical Group or GHS UMG for the patient whose name appears below.

**Medical Consent**

I consent to all treatment given under the general and special instructions of the attending physician(s). Treatment may include, but is not limited to, diagnostic procedures, administration of anesthetics, use of prescribed medication, medical and physical therapy services, the collection and utilization of cultures and laboratory specimens, and referral to specialty services for radiology, physician consultation, and other medical services, all of which may be considered medically necessary or advisable in the judgment of the attending physician or their designees.

If a health care worker comes in direct contact with a patient's blood or body fluids, I understand that the patient's blood may be tested for the Hepatitis B virus, Hepatitis C virus, or HIV (Human Immunodeficiency virus) to determine whether or not the viruses are present, endangering the health care worker (in accordance with South Carolina State Statute title 44, chapter 29, section 44-29-230). The results of the testing will be made available to the patient.

**Assignment of Insurance Benefits and Third Party Claims**

If the account is not paid at time of service, I hereby assign to GHS UMG the proceeds from the following: TRICARE medical benefits; PIP (personal injury protection); sick benefits; physician benefits; injury benefits; any health, accident or welfare benefits of any type or form relating to the patient, whether insured or self-funded; proceeds of any liability settlement or judgment being paid by or on behalf of a third party; and any other benefits due from the insurance policy. All amounts collected will be applied to the patient's account. I understand that I am responsible for any charges not covered by insurance, Medicaid, or other benefits. I further warrant and represent that any insurance or any plan that I assign is valid insurance and in effect, and that I have the right to make this assignment. In the event a claim for payment submitted by GHS UMG to my insurance carrier or plan administrator is denied, I hereby authorize GHS UMG to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. Section 8901 et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management.

**Financial Agreement**

I understand that, if my insurance plan or policy requires a co-payment from me, I am required to pay that co-payment at the time service is rendered. I understand that, if I am self-funded, full payment is due at time of service. I understand that I am obligated to pay the patient account according to the regular rates and terms of GHS UMG. I appoint GHS UMG as my true and lawful attorney to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. In the event benefits exceed the actual charges for this account, the payment will be posted to the intended account and the refund processed accordingly. I understand that GHS UMG may obtain my credit report for review in collection of this debt. In the event that this account is placed with a collection agency or an attorney for collection, I will pay all collection fees and reasonable attorney's fees.

**Medicare Patients**

Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to GHS UMG on my behalf. I certify that the information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

**Disclosure/Use of Health Information**

I authorize GHS UMG to provide any health information related to this patient to the insurance company or other payor, for purposes of payment for the health care provided. I also authorize GHS UMG to provide health information to other physicians and healthcare facilities for continuing care. I further agree that GHS UMG can use the health information for operations such as peer review and outcomes analysis. I acknowledge that I have received a copy of the GHS UMG Notice of Privacy Practices.

**(Patient initial here to acknowledge that Privacy Notice was received.)**

I acknowledge that my agreements hereunder are with and for the benefit of each entity and provider doing business as a part of GHS UMG and may be enforced under the practice name, provider name or as GHS UMG.

**Patient Photographs**

I understand that a facial photograph may be taken at the first visit and periodically thereafter for identification purposes only and that it will be part of my medical record and will be subject to all the protection that other personal health information receives.

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

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

PRINT Name and Relationship if Personal Representative: \_\_\_\_\_

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

*\*University Medical Group is the faculty practice plan of Greenville Hospital System.*



DISCLOSURE OF MEDICAL INFORMATION

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 Hospital System University Medical Group 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 UMG 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) \_\_\_\_\_

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



Greenville Hospital System University Medical Group\*

FINANCIAL POLICY

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

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided by Greenville Hospital System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Hospital System University Medical Group or GHS UMG for the patient whose name appears above.

Payment for Service: Our office will inform you of the amount due when you check out. This amount is due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A \$25.00 service charge will be added on all checks returned to us for insufficient funds.

Non-appointment prescription refills: A \$15.00 charge per incidence may be added for non-appointment prescription refills.

Non-appointment prescription: A \$25.00 charge may be billed to you for new prescriptions filled via phone.

Completion of medical forms: There may be a charge for completion of forms such as disability, camp physicals, etc.

Copies of Medical Records: There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities

- \$.65 per page for the first 30 pages
\$.50 per page for all other pages
Clerical fee not to exceed \$15.00
Plus actual postage

No-show Appointments: A fee of \$25.00 for a follow up visit and \$50.00 for a new patient visit or endoscopy procedure may be charged for all missed appointments not cancelled at least 24 hours prior to the appointment time.

Payment for Services Provided by Certain Non-UMG Providers: If you are having laboratory and/or diagnostic services by providers other than this office or other practices doing business as GHS University Medical Group, you may be billed separately by that service provider.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at 864-454-2000 or 1-888-284-6024 to make payment arrangements.

Questions: We are here to help should you have any questions regarding your statement or insurance.

Signatures: I have read and understand these financial policies.

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

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

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

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



PATIENT INFORMATION

Full Name: \_\_\_\_\_  
Last First Middle

Nickname/AKA: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Month/Day/Complete Year

Address: \_\_\_\_\_  
\_\_\_\_\_

SS#: \_\_\_\_\_  
Sex (Male or Female): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

County: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

PO Box: \_\_\_\_\_ (Required if applicable)

Cell Phone: ( ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Preferred language: \_\_\_\_\_  
\_\_\_\_\_

Preferred E-mail: \_\_\_\_\_  
\_\_\_\_\_

Marital Status: \_\_\_\_\_  
Single, Married, Divorced, Widowed, Partnered

Race: \_\_\_\_\_  
Caucasian (white), Native American,  
African-American (black), Latin, Asian, other

EMPLOYMENT

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

EMERGENCY CONTACT

Only one (1) emergency contact is required

Name: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Relationship: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Optional Name: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Relationship: \_\_\_\_\_

Employer Name: \_\_\_\_\_

**PATIENT INFORMATION**

Full Name: \_\_\_\_\_  
Last      First      Middle

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Month / Day / Complete Year

Address: \_\_\_\_\_  
 \_\_\_\_\_

SS#: \_\_\_\_\_

Sex (Male or Female): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

County: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

PO Box: \_\_\_\_\_ (Required if applicable)

Cell Phone: (\_\_\_\_) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Preferred language: \_\_\_\_\_ Preferred Email: \_\_\_\_\_

Race: \_\_\_\_\_  
Caucasian (white), Native American,  
 African-American (black), Latin, Asian, other

**EMERGENCY CONTACT (other than parent(s)/guardian)**

Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_

**PARENT/GUARDIAN & IMMEDIATE FAMILY INFORMATION**

**MOTHER**

Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last      First      Middle

Maiden Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Month / Day / Complete Year

Address: \_\_\_\_\_  
if different from patient

SS#: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

**FATHER**

Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last      First      Middle

Date of Birth: \_\_\_\_\_  
Month / Day / Complete Year

Address: \_\_\_\_\_  
if different from patient

SS#: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

**BROTHERS, SISTERS, & OTHER FAMILY MEMBERS**

Full Name	M or F	Date of Birth	Relationship	Lives with child	
				YES	NO
				YES	NO
				YES	NO
				YES	NO

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**GHS UNIVERSITY MEDICAL GROUP**

**BILLING INFORMATION**

**ACCIDENTAL INJURY**

Is visit result of an accident? (Examples: auto accident, workers compensation, etc.)

YES / NO Date: \_\_\_\_\_

**GUARANTOR INFORMATION ( This is the person responsible for the balance after insurance pays on the account.)**

*Parent/guardian presenting minor child for treatment will be listed as the guarantor. This person will be responsible for any balances due after insurance has paid. If 18 or older, you are your own guarantor and do not have to complete this section unless there is a legal designation for your care, such as a power of attorney.*

**\*\*\*\*\*IF SELF DO NOT COMPLETE THIS SECTION BELOW\*\*\*\*\***

Guarantor

Name: \_\_\_\_\_ Guarantor SS#: \_\_\_\_\_  
(Last First Middle)

Relationship: \_\_\_\_\_ Primary Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

PO Box: \_\_\_\_\_ (Required if applicable)

City, State, Zip: \_\_\_\_\_

Guarantor Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

**If SELF check this box**

Insurance Co. Name: \_\_\_\_\_

ID#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Patient Employment Status: \_\_\_\_\_  
(full-time, part-time, unemployed, retired, military, retired military, full or part-time student)

**SUBSCRIBER INFORMATION (This is the person insured by the insurance company listed above.)**

**\*\*\*\*\*IF SELF DO NOT COMPLETE THIS SECTION BELOW\*\*\*\*\***

Patient Relationship to Subscriber: \_\_\_\_\_

Subscriber's Full Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
M or F

Address: \_\_\_\_\_ SS#: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Co. Name: \_\_\_\_\_

ID#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Patient Employment Status: \_\_\_\_\_  
(full-time, part-time, unemployed, retired, military, retired military, full or part-time student)

**SUBSCRIBER INFORMATION (This is the person insured by the insurance company listed above.)**

**\*\*\*\*\*IF SELF DO NOT COMPLETE THIS SECTION BELOW\*\*\*\*\***

Patient Relationship to Subscriber: \_\_\_\_\_

Subscriber's Full Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
M or F

Address: \_\_\_\_\_ SS#: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

**AUTHORIZATION**

I authorize medical evaluation & treatment, and release of information for insurance/medical purpose concerning my illness and

Signature of Patient/Guardian/Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

treatment. I hereby, authorize payment from my insurance company to the Greenville Hospital System, University Medical Group for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: \_\_\_\_\_

Date: \_\_\_\_\_