PRISMA HEALTH®

Authorization for Disclosure of Medical Information

Patient Full Name (PRINT)_____DOB_____MRN _____

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? *(Check and complete one)*

YES - The provider may discuss my medical condition with the following family member or other individual:

_____

_____

NO The provider may not discuss my medical condition with any family member or other individual.

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Communication: Please provide phone number(s) where we can reach you. You may allow other people to receive information, by phone or text, about your care (by providing a number you also authorize Prisma Health to leave you voicemails at the number(s) listed). Text messages are unencrypted and are, therefore, considered unsecure communications.

☐Home:_____☐Cell:_____☐Work:_____

Note: *An automated appointment reminder system may call the number listed in our data base.*

Signature: I hereby authorize the disclosure of my medical information as described above.

Patient/Patient's Representative Signature:_____Date:_____Time:_____

PRINT Name (if Patient's Representative): _____

Relationship to Patient (if Patient's Representative):_____

Prisma Health Representative:_____Date:_____Time:____

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GENERAL PERMISSION TO TREAT:

Emergency Department patients: Patients presenting to the Emergency Department have the right to receive an appropriate medical screening exam performed by a doctor, or other qualified professional, to determine whether they are suffering from an emergency medical condition or are in active labor, and if so, to receive stabilizing treatment (including delivery of a baby including the placenta) within the capabilities of the Prisma Health staff and facilities. Patients have these rights even if they cannot pay for services, do not have health insurance, or are not entitled to Medicare or Medicaid.

I am the patient named above (or the person authorized by law to make decisions for the patient). I give permission for Prisma Health and its physicians, healthcare providers, staff, and outside companies to perform routine hospital and healthcare services as applicable: including blood draws, medications, tissue disposal/donation, examinations, treatments, lab tests, anesthetics, therapy, transportation, evaluation and treatment services, and procedures, as may be necessary in accordance with the judgment of the provider(s), including appropriately supervised students, residents, and telehealth providers. **Treatment may be provided by authorized employees of Prisma Health and the University of South Carolina.** I acknowledge that no guarantee can be made concerning the results of treatments.

Diagnostic and laboratory procedures that may be ordered for me (and/or my newborn infant) include (but are not limited to) testing for diseases such as human immunodeficiency virus (HIV), hepatitis, any other diseases categorized as contagious or sexually transmitted diseases, and methicillin-resistant staphylococcus aureus (MRSA). I understand that I can discuss these tests with my health care provider and can tell my healthcare providers (nurses, technicians and physicians) if I do not want to be tested for any one or all of these diseases. If I refuse the tests, I will not be tested. However, if I do not refuse these tests, I may be tested and those results will be included in my medical record. If the test results are positive, the results will be shared with me. If a health care worker comes in direct contact with my blood or body fluids, I understand that South Carolina law allows my blood to be tested without my consent for the hepatitis B virus, hepatitis C virus, or HIV to determine whether or not the viruses are present. The results of the test(s) will be made available to me and to the healthcare worker who was exposed.

Unless otherwise discussed with me, I authorize Prisma Health to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment.

HEALTHCARE PROVIDERS: I understand that doctors who are providing services at Prisma Health are members of the Prisma Health medical staff, but they may not be employees or agents of Prisma Health. Many providers, including doctors, physician assistants, nurse practitioners and certified nurse midwives, are non-employed, independent providers. I understand that Prisma Health is not responsible for any act or omission by a provider who is not an employee or agent of Prisma Health. I also understand that Prisma Health is a medical teaching institution and that students and residents may be involved in my care with appropriate required supervision.

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD-PARTY CLAIMS:
If I have insurance, I agree to assign to Prisma Health any and all rights including money from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, workers' compensation benefits, physician benefits (excluding any benefits payable to physicians who are not employees or agents of Prisma Health), injury benefits, or any other health, accident or welfare benefits of any type or form, whether insured or self-funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from the insurance policy. I also assign to doctors who are not employed by Prisma Health any proceeds of the foregoing benefits being paid by or on behalf of a third party or due from any insurance policy for services provided at Prisma Health (such as pathologists and other private doctors). I warrant and represent that any insurance or any plan which I assign is valid insurance and in effect and that I have the right to make this assignment. All amounts collected will be applied to my account. In the event a claim for payment submitted by Prisma Health to my insurance carrier or plan administrator is denied, I authorize Prisma Health to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of patients; plan or policy, appeal or file a legal/equitable action. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management. In the event I am a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C §1001 et seq., I designate Prisma Health as my authorized representative and grant to Prisma Health the authority to act on my behalf in pursuing and appealing a benefit determination under the plan. Such authority shall include the right to request and receive a copy of the plan description and/or summary of the plan description.

MEDICARE PATIENTS: If I am eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to Prisma Health 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.

FINANCIAL AGREEMENT: I understand that I am obligated to pay my account according to the regular rates and terms of Prisma Health, except for those services, provided in accordance with a clinical research trial, which are specifically identified in writing as services for which I am not obligated to pay. I do hereby appoint Prisma Health as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. To the extent not prohibited by law or contract, I hereby authorize Prisma Health to apply any overpayment it receives to any other account for which I am responsible at Prisma Health or its affiliated entities. If there is no other outstanding account(s) for which I am responsible, the payment will be posted to the intended account and a refund of any overpayment will be processed accordingly.

I understand that Prisma Health 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 be responsible for paying all costs of collection, including attorney's fees.

DISCLOSURE/USE OF HEALTH INFORMATION: Uses and disclosures of my personal and health information are described in the Prisma Health Notice of Privacy Practices (NPP). I acknowledge by signing below that I have had the opportunity to receive a copy of the NPP. I also consent to the following:

- **Directory/Patient door**. Unless I inform hospital personnel otherwise, I consent to my name being listed in the hospital directory, along with my location, general condition, and religious preference to allow clergy visits.

PATIENT RIGHTS: I understand that I have certain rights and responsibilities that are set forth in the Patient Rights and Responsibilities handout. I acknowledge by signing below that I have received a copy of the Prisma Health Patient Rights and Responsibilities Handout.

PERSONAL VALUABLES/BELONGINGS: I agree not to bring dangerous items onto Prisma Health property. Prisma Health reserves the right to search my property and room for dangerous items. I understand that Prisma Health is not responsible for personal property kept in my room including false teeth, glasses, and other prosthetic devices. Prisma Health is NOT responsible for personal property, including money, unless Prisma Health has issued a receipt for safekeeping of the personal property. Prisma Health is a NO SMOKING facility. To ensure safety, I will allow Prisma Health to keep my smoking materials until discharge or may send them home with family or friends. I understand that this policy is strictly enforced.

CONTACTING PATIENTS: I understand that I may be contacted by my provider or Prisma Health and/or Prisma Health entities and its employees and outside contractors including debt collection companies through any contact information that I have provided to my provider, Prisma Health and/or Prisma Health entities for any purposes related to my medical diagnosis, treatment, fundraising, community service, unsolicited advertisements, marketing, payment for services, debt collections for bills owed, or for any other purpose related to treatment, payment or business operations. (This also applies to outside independent companies and doctors and their employees who provide services in or for Prisma Health facilities.) I may be contacted in ways that may cause me to be charged a fee, and I will be responsible to pay the fees related to cellphone, home phone, work phone, text message, email or fax usage for contacts.

I understand that I may be contacted by Prisma Health using automated dialing and/or artificial or prerecorded voice messages when contacting me by cell, home or work phone, patient room phone, paging service, specialized mobile radio service, radio common carrier service, or by or through any other service. I understand that this will allow Prisma Health to call me using phone numbers that I may have listed on National or State Do-Not-Call Registry(s).

Contacting by email or text messaging. To help coordinate your care, your provider will send you text messages and emails that include reminders for scheduling and scheduled appointments, recommended tests, and other information to help you manage your health. The messages may come from your provider, Prisma Health or from our partners who are helping to manage your care. The responsibility of scheduling and canceling appointments will still rest with you, but we hope this service will make things easier.

You may be contacted by Prisma Health using email for transmission of notices regarding billing statements. Such email notices and text messages are unencrypted and are, therefore, considered unsecure communications and will not include information specific to your clinical information, but they may include information that would be of interest to you because of your health condition. When we send text messages, we will never transmit your full name or address in the text message.

If you DO NOT wish to allow contacting in these manners, please notify a Prisma Health team member in the business office/patient access/ registration, respond to the "opt-out" directions in the text message or choose your communication preference in the patient portal.

I understand if I provide my cellphone number, home phone number, work phone number, and email address and do not tell anyone that I do not want to be contacted in the manners described, I am consenting to receive phone calls, text messages and emails for appointment scheduling and other healthcare reminders and information as described above. I will keep my provider informed of my up-to-date mobile number and email address at all times and notify my provider if the mobile number is no longer in my possession.

I understand that even if I do state that I do not wish to be contacted as described above, my provider, Prisma Health or our partners may still contact me by phone call for scheduling and scheduled appointments, recommended tests, and other information to help me manage my health.

PERMISSION TO TREAT

HEALTHCARE ASSOCIATED INFECTIONS: Healthcare-associated infections can be a complication of hospitalization. The SC Hospital Infections Disclosure Act, S.C. § 44-7-2410, requires hospitals to monitor and report targeted healthcare-associated infections to the SC Department of Health and Environmental Control (DHEC). These reports are available on the following website for public view: http://www.scdhec.gov/Health/FHPF/InfectionControlHIDA/HospitalInfectionControl/

I understand that the practice of medicine and the security of personal or health information is not an exact science and that not all risks can be eliminated and that NO GUARANTEES HAVE BEEN MADE TO ME.

I SIGN BELOW ACKNOWLEDGING THAT I HAVE READ, ASKED QUESTIONS AND UNDERSTAND AND AGREE TO ALL FOUR PAGES OF THIS FORM.

DATE/TIME	SIGNATURE OF WITNESS	SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE
DATE/TIME	SIGNATURE OF SECOND WITNESS (NECESSARY ONLY FOR TELEPHONE CONSENT)	PRINT NAME AND RELATIONSHIP IF OTHER THAN PATIENT