Westside Internal Medicine, LLC

HIPAA Privacy Authorization Form

I, _____ (patient/guardian name) allow Westside Internal Medicine, LLC to release information about my care in the following manner (information will not be released in any other matter without patient/guardian consent):

___ To only me personally
___ By mail/email
___ To my parent _____
___ On my voicemail
___ To my spouse _____
___ Other (specify) _____

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.
2. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim.
3. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Patient Signature Printed Name Date

Prescription Medication Consent

The providers at Westside Internal Medicine, LLC use an electronic medical record system that allows electronic prescribing of medications. This system also has the ability to access any other medication history prescribed in the past from other providers. Please check one of the following:

___ I **do** allow access to my medication history
___ I **do not** allow access to my medication history

Patient/Guardian Signature _____ Date _____

Agreement to Bring In Medicine Bottles

I, _____, agree to bring my medication bottles to all my appointments. I understand that failure to do so will prevent me from getting any refills. I will have to come back for another appointment and pay a separate co-pay if I want refills on my Medicine.

Patient Signature_____Date_____

Authorization for Release of Medical Records

Westside Internal Medicine, LLC
3070 Reidville Rd
Spartanburg SC 29301
P: (864) 576-5764 F: (864) 587-3969

Patient Name: _____ DOB: _____

Address: _____

City / State / Zip: _____

Authorization of Release of:

All Medical Records, i.e. X-rays, and Diagnostic Tests, Etc...
_____
_____

To be released to:
Westside Internal Medicine Date: _____

Phone: (864) 576-5764 Fax: (864) 587-3969

_____ Date: _____
Signature of Patient or Personal Representative

Description of Personal Representative's Authority (Attach necessary documentation)