Rockhill Women's Care

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Dear Patient,

In order to protect your confidentiality and to comply with government regulations (HIPAA), Rockhill Women's Care is required to obtain authorization from you in order to release messages and/or provide information regarding your care with any person(s) other than yourself.

RELEASE OF MEDICAL INFORMATION:

The physicians and staff at Rockhill Women's Care may discuss my medical information and/or care with the following.
(Please check all that apply and list the names.)

- ○ My Spouse (name) _____
- ○ Name _____Relationship _____
- ○ Name _____Relationship _____

To improve the continuity of your medical care information regarding your visits will be forwarded to your Primary Care Physician.

- ○ Primary Care Physician _____
- ○ Phone _____Fax _____

MESSAGES:

I give my consent to the physicians and staff of Rockhill Women's Care to leave or discuss treatment, surgery, lab, and radiology results or other information regarding my care as follows.
(Please check all that apply)

- ○ On answering machine or voice mail at home @ _____.
- ○ On cell phone @ _____.
- ○ I do not consent to messages being left at home, work or with any other person.

ePRESCRIBE: I give my consent by authorizing Rockhill Women's Care to access my prescription(s) history from the electronic system, Sure Scripts.

Interoperability: I give my consent by authorizing Rockhill Women's Care to access my medical history with Epic and Cerner hospital systems through Carequality & Common Well for the most complete and up-to-date records.

I hereby acknowledge that I have received Rockhill Women's Care's Notice of Privacy Practices. (HIPAA)

Patient's Name: _____Date of Birth: _____
(Please Print)

Signature: _____Today's Date: _____
(Patient Signature Only)