Communication with Friends, Family, or Others Involved in Your Care

Palmetto Health **USC**
MEDICAL GROUP

Patient Name | DOB | MRN

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition?

If you are present and do not object, Palmetto Health-USC Medical Group providers may discuss or share your health information with family members, friends, or others involved in your care or payment for your care. We may 1) ask your permission, 2) may tell you we plan to discuss the information and give you an opportunity to object, or 3) may decide, using our professional judgment, that you do not object. We may discuss only the information that the person involved needs to know about your care or payment for your care.

I understand that I have the right to refuse to sign this authorization and that the Palmetto Health-USC Medical Group, will not condition my treatment on whether I provide authorization for the requested use or disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law. I understand that I have the right to withdraw this authorization by sending a written notice to the Palmetto Health-USC Medical Group I understand that withdrawal is not effective for actions taken prior to the withdrawal.

If you are not around or cannot give permission, we may share or discuss your health information with family, friends, or others involved in your care or payment for your care if we believe, in our professional judgment that it is in your best interest. When someone other than a friend or family member is asking about you, we must be reasonably sure that you asked the person to be involved in your care or payment for your care. We may only share the information that the family member, friend, or other person needs to know about your care or payment for your care. Palmetto Health-USC Medical Group will verify the identity of any person not known to us prior to disclosing health information.

If you would like to name specific family, friends, or others involved in your care or payment for your care with whom you would like us to share your health information, please list them in the space provided below. If you are not around or cannot give permission, we may rely on this information until you notify us otherwise; however, we may use our professional judgment to determine whether sharing your health information with these or other individuals is in your best interest.

Name of family member, friend, or other person involved in patient's care or payment for care	**Relationship to patient/involvement with patient's care or payment for care**

Patient's Signature or Legally Qualified Representative | Date/Time

Patient/Guardian Print Name | Relationship to Patient

Palmetto Health-USC Medical Group Representative | Date/Time