Southside Medical Center

3919 South Hwy 14 Building A
Greenville, SC 29615

Patient Full Name (PRINT) _____ DOB _____

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 cannot 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.

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 (circle 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 (circle 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 or Guardian Signature:_____Date:_____

PRINT Name of Patient or Guardian: _____ Date: _____

SMC Representative: _____ Date: _____