# TRUESDALE MEDICAL CENTER / PALMETTO COMMUNITY CARE

**AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION**

## Information to be released to:

Truesdale Medical Center / Palmetto Community Care
5064 Rives Avenue
N. Charleston, SC 29406
843-266-3870 phone
843-255-3674 fax

## Information to be released from:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

- By initialing the space below, I authorize the following information to be released/disclosed:
  _____ Complete Medical Record

- By initialing the space below, I authorize ONLY the following information to be released/disclosed:
  _____ Office Notes _____ Radiology/Imaging _____ Lab/Pathology _____ Prescription

  _____ Other _____

- By initialing the space below, I authorize the above information released/disclosed to include:
  _____ Treatment of Drug & Alcohol Abuse
  _____ Psychological or Psychiatric Impairments
  _____ Human Immunodeficiency Virus (HIV) & Acquired Immunodeficiency Syndrome (AIDS)

- By initializing below, I certify (declare) the purpose of the release/disclosure is for:
  _____ Medical Review _____ Legal Review _____ Insurance _____ Continuity of Care
  _____ Other _____

I understand that I have a right to revoke this authorization at any time by notifying Truesdale Medical Center in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that any revocation does not apply to the acceptable and lawful releases under the Notice of Privacy Practices.
I hereby authorize the use or disclosure of my identifiable health information as described above. The facility, its employees, officers and providers are hereby released from any legal responsibility or liability for the release and disclosure of the above information to the extent indicated and authorized herein.

I understand that I may be charged for copies of my records based on Truesdale Medical Center's policy. Current rates apply.

PATIENT NAME:_____ PATIENT PHONE: _____
**PLEASE PRINT NAME**

SIGNATURE: _____ PATIENT BIRTHDATE: _____
**LEGAL GUARDIAN IF MINOR OR LEGAL REPRESENTATIVE**

DATE: _____ Date of Expiration: _____

Truesdale Medical Center

5064 Rivers Avenue
North Charleston, SC 29405
truesdalemedical.org
palmettocare.org

TMC Office - 843-266-3870
PCC Office - 843-747-2273
Fax - 843-225-3674

Palmetto Community Care

# HIPAA-ACKNOWLEDGEMENT OF RECEIPT

## Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date: _____

We at Truesdale Medical Center and Palmetto Community Care are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at 843-747-2273. A copy of the Notice is available upon request.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient

# Palmetto Community Care

## CLIENT RIGHTS

- **Privacy & Confidentiality** You have the right to full and complete confidentiality as guaranteed to you under Federal and State Laws. Information regarding any personal or medical information will **NOT** be shared with other health care providers, family members, or significant others unless you sign an authorization for the release of information. Exceptions to this are in situations where PCC employees reasonably believe you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In that case, PCC will disclose client information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others. (See Safety Policy)

- **Client to Client Breach of Confidentiality** You have the right to complete confidentiality as guaranteed to you under Federal and State Laws. You may not disclose any fellow clients that you see on the premises receiving services and the same shall hold true for you to protect your privacy and confidentiality. (See Client to Client Privacy Policy)

- **Considerate & Respectful Care** You have the right to receive courteous, ethical, prompt, and dignified treatment without discrimination based on age, race, religion, gender, national origin, economic status, sexual orientation, or disability.

- **Access to Services** You have the right to be informed about what services PCC provides and how to obtain these services, including, appropriate referrals to other services/agencies. You have the right to a clear explanation of why you were refused services at PCC in the event that you are refused services. You have the right to "due process" in the event that you are involuntarily discharged from service. You have the right to terminate services with PCC at any time.

- **Grievance** You have the right to have any grievance heard if at any time you feel your civil rights have been violated.

- **Review** You have the right to review your records. (See File Access Policy)

## CLIENT RESPONSIBILITIES

- **Current Information** You have the responsibility to give PCC accurate and current information about your health status, health behaviors, your financial status and changes of your contact information including address and/or phone numbers. *Information must be honest and truthful.*

- **Keeping Appointments** You are responsible for keeping appointments, or for notifying the PrEP navigator when that is not possible. Appointments will be cancelled if you are more than 30 minutes late, and missing 3 consecutive appointments may result in removal from the PrEP program.

- **Financial Responsibility** PCC offers free services and will enroll you in assistance programs designed to offset the cost of your PrEP prescription and lab work. It is your responsibility to check your co-pay and keep your information up-to-date for financial assistance eligibility. You are fully and solely responsible for costs incurred beyond of the assistance PCC has provided.

- **Quarterly Testing** PrEP prescriptions are written in quarterly doses (3-month supply). You must be seen at PCC for testing and lab work and TMC for review of labs every 3 months or you will not receive a prescription refill. If you fall out of care or become non-compliant with medical care, additional contact may be required and may include contact with your emergency contact, phone calls, letters and/or home visits. However, all contacts will be done discreetly to protect your confidentiality with the purpose of re-engaging you in medical care.

I accept and understand these Rights and Responsibilities. I understand that failure to follow these Rights and Responsibilities could limit or terminate services provided to me by PCC.

Client's Signature: _____ Date: _____

Case Manager's Signature: _____ Date: _____

CLEAR FORM

# Palmetto Community Care

**AUTHORIZATION TO CORRESPOND BY ELECTRONIC COMMUNICATION**

I,_____authorize Palmetto Community Care to correspond with me through electronic communication to include email and fax. I acknowledge and consent to the following:

☐ Electronic communication is not appropriate for urgent or emergency situations.
☐ Electronic communications related to services received from PCC will be recorded in your electronic record, just as telephone calls are.

I, _____understand that Palmetto Community Care will use reasonable means to maintain security and confidentiality of electronic communication information sent and received; however, I also understand that there are risks of using electronic communication to include, but are not limited to, the following: 1. Electronic communications can be intercepted, altered, forwarded or used without authorization or detection. 2. Electronic communications can be circulated, forwarded and stored in paper and electronic files. 3. Electronic communication senders can type in the wrong e-mail address. 4. Electronic communications may be lost due to technical failure during composition, transmission and/or storage.

I, _____have read and fully understand the information in this authorization form. I consent to the Electronic Communication conditions and agree to abide by the guidelines listed above. I further understand that this electronic communication relationship may be terminated if I repeatedly fail to adhere to these guidelines. I understand and accept the risks associated with the use of unsecured electronic communications. I further understand that, as with all means of electronic communication, there may be instances beyond human control where information may be lost or inadvertently exposed, such as during technical failures.

I acknowledge the privacy risks associated with using electronic communications and authorize the staff of Palmetto Community Care to communicate with me for the purposes of services received by Palmetto Community Care.

Client Signature: _____Date:_____

Staff Signature: _____Date:_____

# Palmetto Community Care
## AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION

I, _____,DOB:_____hereby authorize the following name/agency:
Address:/Phone Number: Palmetto Community Care 5064 Rivers Ave North Charleston, SC 29406.

**To release/obtain the following information:** Information needed to access PrEP, 340B, and/or medical services. Records to be released include client profile, client service profile, HIV/TB condition, diagnosis, drugs, progress logs, services provided, test/lab results, and vaccinations.

To/From: Palmetto Community Care
5064 Rivers Avenue
N. Charleston, SC 29406
843-747-2273 (phone)
843-745-0431 (fax)

I hereby request and authorize the above named agency, organization or individual which possesses information relative to the client named above to release/exchange information, as specified, to/from the agency, organization or individual named on this request. I understand that the information to be released/exchanged may include information about substance abuse, psychological or psychiatric impairments, and HIV/AIDS. This information may be transmitted electronically through fax or the Provide database system. **I UNDERSTAND THAT INFORMATION TRANSMITTED BY FAX IS NOT GUARANTEED TO REMAIN CONFIDENTIAL**. I understand that any information transmitted may not reach its intended destination and could reach any type of destination. I understand my right to confidentiality is protected under federal and state law. I acknowledge that my signature on this form is voluntary and valid. Signing this authorization, releases this facility and its employees from any legal responsibility as a result of any information being transmitted by fax. I understand that a copy or fax of this authorization is as effective as the original. "I also understand that Palmetto Community Care owns Truesdale Medical Center and that, because of their affiliation, both share private access to all patient medical information."

## Information to be Released

**For Client Eligibility and Service History**:
X Client Profile
X Action Plan/Goals/Steps (Case Management)
X Appointments
X Assessment(s)
X Applications and Care Action(s)
X Condition
X Discharge
X Mental Health Services Only (No Case Notes)
X Pregnancy and Perinatal Services (If applicable)
X Prescription/Refill History
X Provider Reimbursement (Premium Payments)
X Scan documentation
X Service Plan (Case Management)
X Services Provided
X Service Request
X Substance Abuse Services Only (No Case Notes)

**For Clinical Quality:**
X Allergy
X Biopsy
X Care Plan (Medical)
X Diagnosis
X Drugs Prescribed
X Hospitalizations
X Injection/Vaccines
X Lab Panel
X Medical Encounters (Medical Visit History)
X Medical Problems (Co-conditions)
X Procedure
X Radiology/Ultrasound orders and results
X TB Assessments
X Test Results
X Treatment/Prophylaxis
X Clinical information selected but not stored in Provide Enterprise

I understand that my records are protected under Federal regulations governing Confidentiality of Alcohol and Drug Use Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by dating and signing the revocation below, except to the extent that action based on this authorization has been taken. I understand my refusal to give authorization in no way jeopardizes my right to obtain present or future services.

Client Signature: _____Date: _____

Client Date of Birth: _____ Client Social Security Number: _____

I chose to revoke this consent effective:_____Client Signature for revocation:_____

# PrEP Referral Form

**Wolf ID**: _____

Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary

Insurance: ☐ Insured (carrier) _____ ☐ Uninsured

Last HIV test date: _____ Location: _____

Referring tester: _____

Notes: _____

_____

## Important Information

- PrEP services at Palmetto Community Care require regular medical follow up and communication with the agency to ensure continued eligibility
- **Palmetto Community Care has the right to revoke services if clients no longer meet or fail to maintain eligibility terms**

**For more information about PrEP:**

Kiara Johnson
Office: 843-747-2273
Cell: 843-310-9390
E: kjohnson@palmettocare.org

# PATIENT ENROLLMENT

phone 800-633-3977 fax 800-615-0075 avitapharmacy.com
1431 West Innes Street • Salisbury, NC 28144

| DATE | NEEDS BY DATE | SHIP TO: ❑ PATIENT ❑ OFFICE - FIRST DOSE ❑ OFFICE - ALL DOSES ❑ OTHER: |
|---|---|---|
| REFERRED BY | | TEL |

## PATIENT INFORMATION

ALL INFORMATION IS CONFIDENTIAL AND USED FOR CLINICAL PURPOSES ONLY

| Patient Name | | Preferred Name | |
|---|---|---|---|
| Main Phone | Alternative Phone | Date of Birth | Social Security # |
| Address | | City, State, Zip | |

Sex
❑ Male ❑ Female ❑ Intersex ❑ MtF Female ❑ FtM Male ❑ other:

| Gender Identity ❑ Male ❑ Female ❑ Transgender ❑ Non-Binary ❑ other: | Pronouns |
|---|---|
| Allergies | ❑ HIV ❑ PrEP |

## PRESCRIBER INFORMATION

| Prescriber Name | |
|---|---|
| Address | City, State, Zip |
| Office Contact | Phone |

## INSURANCE

PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

| Ryan White Eligible ❑ Yes ❑ No | Ryan White Eligibility Period | 340B Eligible ❑ Yes ❑ No | ❑ Do not bill Medicaid as Secondary |
|---|---|---|---|
| ❑ Private Insurance ID#: | | ❑ Medicaid ID#: | |
| ❑ Medicare Part D ID#: | | ❑ Other: | ID#: |

## FINANCIAL ASSISTANCE

❑ Meets requirements for clinic's financial assistance program ❑ Clinic Pays All ❑ Patient Pays All at 340B Price ❑ Clinic Pays Copays

## PRESCRIPTION INFORMATION

❑ Written Below ❑ E-Prescribed ❑ Phoned In ❑ Faxed Separately ❑ Compliance Packaging ❑ Spanish Instructions

| MEDICATION | DOSE/STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| ❑ | | | | |
| ❑ | | | | |
| ❑ | | | | |
| ❑ | | | | |

**Dispense As Written** (no stamps) **Date** **Substitution Permitted** (no stamps) **Date**

1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
4. Prescribers must comply with any of their state-specific prescription requirements.

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