



Palmetto Adult and Children's Urology

2890 Tricom Street
North Charleston, SC 29406
Telephone: 843/797-6600
Fax: 843/820-1440

104-C Morgan Place
Summerville, SC 29485
Telephone: 843/879-9163
Fax: 843/879-9952

302 Medical Park, Ste 207
Walterboro, SC 29488
Telephone: 843/549-7122
Fax: 843/549-3257

Nelson R. Ploch, MD Theodore E. Brisson, MD S. Walker Nickles, MD Georgia Anderson, PA

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All my health information maintained by _____
Include: Alcohol/Drug Treatment Records HIV/AIDS Records Mental Health Records
- My health information relating to the following treatment or condition: _____
- My health information for the date(s): _____
- Other: _____

You may disclose this health information to:

Palmetto Adult and Children's Urology - Nelson Ploch, MD, Theodore Brisson, MD, and S. Walker Nickles, MD
2890 Tricom Street, North Charleston, South Carolina 29406
Phone: (843) 797-6600 **Fax: (843) 820-1440**

Reason(s) for this authorization (check all that apply):

- at my request
- other (specify) _____
- request electronic copy

This authorization ends:

- at six months from the date of this document, or on the following date _____
- when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office; or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Printed name if signed on behalf of the patient

Date

Relationship (parent, legal guardian, etc.)