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: _____

Circle your provider: Nelson R. Ploch, MD Theodore E. Brisson, MD S. Walker Nickles, MD Georgia Anderson, PA

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 Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, etc.)