Urology Associates OF CHARLESTON

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize _____

Address:_____

Phone: _____ Fax: _____

To release information from my records to:

[ ] Urology Associates of Charleston, LLC
1122 Chuck Dawley Boulevard, Suite 200
Mount Pleasant, SC 29464
PH (843) 884-8045 FAX (843) 881-5081

[ ] Urology Associates of Charleston, LLC
300 Callen Boulevard, Suite 220
Summerville, SC 29486
PH (843) 884-8045 FAX (843) 881-5081

[ ] Urology Associates of Charleston, LLC
2093 Henry Tecklenburg Drive, Suite 318E
Charleston, SC 29414
PH (843) 884-8045 FAX (843) 881-5081

The purpose or need for this release of information is: _____
_____

The Specific information to be disclosed is:

[ ] Physician's chart notes
[ ] X-Ray reports
[ ] Ultrasound report
[ ] Pathology Reports
[ ] Other _____
[ ] Operative Reports
[ ] Urological related records
[ ] Financial records
[ ] CT Scan

Information which may not be disclosed:_____

Note: Special dates of interest: _____ to _____

I understand that this authorization is subject to written revocation by me at any time except in those circumstances in which action has been taken in reliance of it.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders of mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

By signing below, I hereby authorize the disclosure of information about me that is protected under federal law, for the sole purpose and time period designated. I understand that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.

Urology Associates
OF CHARLESTON

Authorization for Use and Disclosure of Protected Health Information

Authorization must be signed by the patient, or patient's legal representative.

Patient Name: _____SSN: _____

Address: _____ Date of Birth: _____

I understand this authorization will expire one year from the date signed unless otherwise specified:

_____
Expiration Date

_____ _____
Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am: _____

_____ _____
Witness Date