Neurology
Specialists of Charleston
www.NeurologyCharleston.com

David Stickler MD
2695 Elms Plantation Blvd – Suite B
Charleston, SC 29406
Phone: 843-410-0924
Fax: (843) 818-1145
www.NeurologyCharleston.com

Consent to Release/Disclose Patient Records/Medical Information

(Please Print ALL Information Unless Otherwise Noted)

Patient's Name: ____ Date of Birth: ______________________

Address: ____

City: ____ State: ____________ Zip Code: _________________________

Patient's Phone Number: (_____) - ____________________

Requesting my protected health information from the following physicians/facility:

Physician/Facility Name: ____

Address____

City: ____ State: ______________ Zip Code: _________________________

Facility Phone Number: (_____) - ______________________ Facility Fax Number: (_____) - ______________________

By signing this form, I am requesting and authorizing you to release and transfer the following confidential health information about me to the physicians/person/facility below.

Neurology Specialists of Charleston – David Stickler, MD
2695 Elms Plantation Blvd – Suite B
Charleston, SC 29406
Phone Number: 843-410-0924
Fax Number: 843-818-1145

______ **I understand this authorization will not expire, but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.**

______ **I understand that I have the right to inspect and receive a copy of the information that is to be released.**

______ **I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide me with the most appropriate care.**

______ **I understand that the release of information may NOT be re-released to any other person or organization without my written consent.**

______ **I authorize release of my medical records in accordance with the specification listed above. I understand written notice is necessary to cancel this request.**

____

Print Name of Patient/Personal Representative

____ ______________________________

Signature **Date**