901 Von Kolnitz Road
Suite 100
Mt. Pleasant, SC 29464
P 843-216-3376
F 843-216-3242

MEDICAL RECORDS RELEASE FORM

Request Records From: ____
____
____

Records to be sent to: ____
____
____

I request a copy or summary of the following medical records:

- o Complete Medical Records
- o Biopsy Report(s)
- o Lab Report(s)
- o Consultation Reports
- o Medication Allergies
- o Surgical Procedures
- o Other____

For dates of service from_____________________to____________________________

Additional Comments:____
____

Patients Name (Please Print)____

Patients DOB____

Patient Signature______________________________ Date___________________________

Witness_______________________________________Date___________________________