

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (please print)

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE RELEASE ALL MEDICAL RECORDS FOR TRANSFER OF PATIENT CARE

**FROM:**

NAME OF PRACTICE: Liberty Doctors, LLC d/b/a Dennis Fisher, MD

PRACTICE FAX: 843-763-2949

**TO:**

NAME OF PRACTICE:

PHONE NUMBER:

FAX NUMBER:

Please release a copy of all medical records, including but not limited to: vaccine records, progress notes, operative notes, laboratory / x-ray results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF ALL MEDICAL RECORDS

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Return completed form to fax #: 843-763-2949 or mail to Liberty Doctors Corporate office address: 8761 Dorchester Road, Suite 230, North Charleston, SC 29420***