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: 843-225-3549

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 #: 843-225-3549 ***or mail to Liberty Doctors Corporate office address: 8761 Dorchester Road, Suite 230, North Charleston, SC 29420***