CHARLESTON
ORAL and FACIAL
SURGERY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

You are authorized to release any and all medical records related to my medical condition and treatment that I may have had during the following time period listed immediately below:

To the following person(s), company, or government institution:

Name:_____

Location: _____Phone Number: _____

Medical information needed: _____

Notes: _____

Attention: _____Fax number: _____

Please send documents via: FAX EMAIL MAIL

Fax: 843-762-9030 office@charlestonoralandfacialsurgery.com Office Addresses listed below

A photocopy of this authorization shall have the same force and effect as an original.
All prior authorizations are canceled.

I have executed this document on the _____ day of _____ (20) _____.
This Authorization Is Valid For 60 Days From The Date Of Execution.

Name of Patient: _____

Signature of Patient: _____

Address of Patient: _____

City, State, & Zip Code: _____

Phone Number: _____

Date of birth: _____ Social Security Number: _____

My initials here indicate authorization to release all medical records requested: _____