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: _____

PRACTICE FAX: _____

PRACTICE PHONE: _____

TO:

LIBERTY DOCTORS, LLC d/b/a TIFFANY PEDIATRICS

215 Town Creek Road

Aiken, SC 29803

PHONE NUMBER: 803-508-7651

FAX NUMBER: 803-508-7655

Email: Tiffany.records@libertydoctors.com

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 _____

Authorized Witness: _____ Date: _____