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Consent for Release of Information

Patient Name: _____ Date: _____

Birthdate: _____ Social Security Number: _____

Address: _____

Telephone: _____

RELEASE INFORMATION FROM MT. PLEASANT OB/GYN, PA

To: _____

Address: _____

Phone: _____ Fax: _____

OR

SEND INFORMATION TO MT. PLEASANT OB/GYN, PA

1400 Hospital Drive, Mt. Pleasant, SC 29464 * 843-884-0301 * Fax 843-884-9620

From: _____

Address: _____

Phone: _____ Fax: _____

Information to be released:

Purpose of Records Release: _____

This facility, its employees, and officers, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent and authorization herein.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____