E-mail Print

Hilton Head Occupational Therapy
Myofascial Rehabilitation & Lymphedema Services

Suite 502
29 Plantation Park Drive, Bluffton, SC 29910
Tel. (843) 757-9292 Fax (843) 757-9294

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To:

_____
(Complete Name of Doctor or Hospital)

_____
(Complete Address – Please include Zip Code)

I hereby authorize and request you to release my complete medical records to include pathologies and surgical history in your possession, concerning my illness and/or treatment during the period from:

_____.

Please release these records to Hilton Head Occupational Therapy, whose address is shown above. Thank you for your attention in this matter.

Patient Full Name: _____

Patient Date of Birth: _____ Social Security Number: _____

Patient's Current Address: _____

_____

Patient or Guardian Signature: _____

Date: _____

Witness Name (Please Print): _____

Witness Signature: _____

Date: _____