Medical Release Authorization

Patient Name: (Please Print)	Date of Birth: (mm/dd/yyyy)

I Authorize:

Name of Sending Person/Organization: ________________________________

Address: ____

City, State, Zip: ____

Phone Number: ______________________Fax Number: __________________

To Release To:

Grand Strand Retina, PC/ Dr Charles J Doering
14361 Ocean Highway, Suite 2B
Pawley's Island, SC 29585
(P) 843-651-3937
(F) 843-651-3940

I request and authorize the release of my health information noted below:
All Healthcare information, Lab Reports, Pharmacy Reports, X-Ray reports, other ___________________________.

- I understand that I am entitled to receive a copy of this authorization.
- I understand that I may withdraw this authorization in writing at any time.
- Unless otherwise specified below. I understand that this authorization will expire 90 days from the request date. I request that this authorization expire on (specify date):__________________.

____ ____________________
Signature Date

____ ____________________
Legal Representative Name Relationship to patient