PATIENT REQUEST FOR RECORD

Date: _____

TO: _____
(Doctor/Hospital)

Address: _____

City: _____ **State:** _____ **Zip:** _____

I hereby authorize the release of my _____ **or copies of Such and request that they be transferred to:**

DR. ANTHONY C. ROSS
(843) 559-9111
(843) 559-5525 fax
PO BOX 1149
JOHNS ISLAND, SC 29457

Print Patient's Name _____

S S # _____

Date of Birth _____

Date of Records _____

Patient's Signature _____

Witnessed _____

PATIENT REQUEST FOR RECORD