Records Release/Request

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:

Palmetto Dental Associates
3359 Hwy 9 E
Little River, SC 29566
843-399-2525

_____
Print Name of Patient

From_____To:_____
Date of Records

_____
Patient's Signature Date