



**ST. JAMES FAMILY MEDICINE
 DR. AMY FORREN
 149 ST. JAMES AVENUE
 GOOSE CREEK, SC 29445
 PHONE (843) 553-0526
 FAX (843) 553-4410**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

From the medical record of:

Patient Name: _____

Birth date and/or SSN: _____ **Phone:** _____

I, _____ hereby authorize
 (Patient name)

Doctor/Facility: _____

Address: _____

**To release to ST. JAMES FAMILY MEDICINE
149 ST. JAMES AVENUE GOOSE CREEK, SC 29445**

This information also includes examination of all hospital/office records, imaging reports and furnishing of any information including opinions. You are further requested not to disclose such information to any other person without written authority to do so.

(Patient signature)

(Date)