Moncks Corner Pediatrics, LLC
5000 Epson Plantation Drive, Suite B
Moncks Corner, SC 29461-3979

Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: ____/____/_____

Current Address: _____ City: _____

State: _____ Zip Code: _____ Contact Number: _____/_____/_____

☐ **I authorize Moncks Corner Pediatrics, LLC to obtain information from:**

Physician / Medical Facility: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Contact Number: _____/_____/____ Fax: ____/____/_____

☐ **I authorize Moncks Corner Pediatrics, LLC to disclose/release all requested information to:**

Physician / Medical Facility: _____

Address: _____ City: _____

State: ____ Zip Code: _____ Contact Number: _____/_____/_____ Fax: ____/____/_____

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Date