Angel Oak Eye Center

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Date: _____/_____/_____

To: _____ From: _____

Fax: ( ) _____-_____

Phone: ( ) _____-_____ Pages: _____(including cover)

Comments:

RECORDS RELEASE/REQUEST

To: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize the release of my medical records or copies of such and request that they be transferred to:

Angel Oak Eye Center, LLC
PO Box 874
Johns Island, SC 29455
Phone: 843-559-5333
Fax:843-559-5339

Patient Print Name: _____DOB_____

Patient Signature: _____