



Angel Oak Eye Center

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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: _____