Charles D. Graham, MD
Charles S. Holladay, MD
Douglas L. Michaelsen, MD
Julia H. Saylors MD

Release of Medical Records Information

Patient Name: _____ Date of Birth _____

Address: _____

Phone: _____SS# _____

I authorize the Charleston Cancer Center to release/request (circle one) the following:

Information to release/requested:_____

_____

From (name, address, phone, fax):

_____

Reason for request: _____

Please send information to (name, address, phone, fax):

_____

- I understand that this authorization shall be valid and in effect until revoked by the patient or representative signing the authorization.

Signature _____ Date _____

Witnessed by _____ Date _____

2910 Tricom Street, Charleston, SC 29406
843/572-9211, Fax 843/572-0457