



AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Prior Facility Name: _____

Patient Name: _____
Last First Middle

DOB: _____ Social Security Number: _____

I authorize you to release my medical records/medical information to Imaging Specialists.

Please send my records or fax them to:

Imaging Specialists
1241 Woodland Ave.
Mt. Pleasant, SC 29464

Phone Number: 843-881-4020

Fax Number: 843-881-7515

Signature: _____

Date: _____

Witness: _____