DR. CRYSTAL L. FRANKLIN
8247 Ocean Highway
Pawleys Island, SC 29585
Phone: 843-314-9064
843-314-9065
Fax: 843-314-9066

Authorization for Release of Medical Records Form

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone #:_____

I, _____, certify the above request is accurate and hereby authorize the
(Patient's Name)

release of these records.

From: _____ To: _____

Address: _____ Address: _____

_____ _____

Phone #: _____ Phone: _____

Fax #: _____ Fax: _____

I request that my records be released by: ☐ fax ☐ mail ☐ prepare for pick-up ☐ electronically

We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you do have the right to revoke it at a later date. If you choose to revoke it, you must submit a typed or written letter informing us that your authorization has been revoked.

I HAVE READ THIS FORM AND UNDERSTAND THE CONTENT ENCLOSED. I AM SIGNING THIS FORM VOLUNTARILY AND I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED ABOVE.

I agree to pay all of the fees associated with this release, based on the standard fees outlined below. I understand that all sections of this form must be completed before it can be processed

_____ _____
Patient's Signature (Parent or Guardian if under 16 years of age) Date

---

For Office Use Only

Records Printing Fee: $30 Date Received: _____

Certified Mailing Fee: $10 Date Processed/Released: _____

Employee's Signature: _____