

Authorization for Release of Medical Records

Westside Internal Medicine, LLC

3070 Reidville Rd

Spartanburg SC 29301

P: (864) 576-5764 F: (864) 587-3969

Patient Name: _____ DOB: _____

Address: _____

City / State / Zip: _____

Authorization of Release of:

All Medical Records, i.e. X-rays, and Diagnostic Tests, Etc...

To be released to:

Westside Internal Medicine _____ Date: _____

Phone: (864) 576-5764 _____ Fax: (864) 587-3969 _____

Signature of Patient or Personal Representative Date: _____

Description of Personal Representative's Authority (Attach necessary documentation)