Temple Simpson, PA-C
Kimberly B. Pugh, MD
Amy Turner, PA-C
John Schenck, MD

Medical Record Release Form

Patient Name:_____

Date of Birth: _____ Phone Number: _____

I authorize the following party:

_____

to use or disclose the following health information:

□ - All of my health information

□- My health information related to the following treatment or condition:

_____

□- My health information covering the period from (date)_____ to (date) _____

□- Other:_____

The above party may disclose this health information to the following recipient:

Magnolia Endocrinology
204 Parsons Road
Summerville, SC 29483
P. 854.201.ENDO F. 854.201.1983

This authorization ends:

□- On Date: _____

□- When the following event occurs: _____

Patient Signature _____ Date_____

Thank you for choosing us to take care of your needs!