Patient Authorization for Release of Medical
Records from Another Office to Our Office

TO: _____

_____

_____

I hereby authorize release of all my medical records in your possession (including office visit notes, operative reports, lab reports, MRI, X-Rays or any other imaging studies) to be disclosed and forwarded (by mail, delivery, or facsimile) to the following:

Joseph P. Tobin, M.D.
Tobin Bone and Joint Surgery, Inc.
12 Lafayette Place, Suite A
Hilton Head, SC 29926
FAX 843 342-9101
Phone 843 342-9100

Please send these records as soon as possible.

Sincerely,

_____ _____
Patient Signature Today's Date

_____ _____
Print Patient Name Patient Date of Birth

_____
Patient's Social Security Number