AUTHORIZATION TO OBTAIN MEDICATION INFORMATION

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Printed Patient Name: ____

Date of Birth: ____________________________ Today's Date: ____________________________

I hereby authorize (Name of Pharmacy): _______________________________

Street Address or PO Box: ____

City, State and Zip Code: ____

FAX: ___________________________ Telephone: __________________________

To furnish Charleston Oculofacial Plastic Surgery my current prescription records.

Patient or Guardian Signature ____