CHARLESTON OCULOFACIAL
PLASTIC SURGERY

Medical Information Release Today's Date:

_____

Printed Patient Name:

_____

Patient Signature:

_____

During the course of your care in our office, you may wish to have a family member, or a friend assist you in scheduling appointments, setting up procedures, or obtaining medical information.

An authorization is necessary for our staff to release any information regarding your care.

Please list below any person(s) to whom you authorize the release of information regarding your care with Charleston Oculofacial Plastic Surgery

Name	Relation	Date	Revoke
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
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