MAGNOLIA MEDICINE

DIRECT. PERSONALIZED. COMPREHENSIVE.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO MAGNOLIA MEDICINE

Patient's Full Name_____Date of Birth_____

Street Address_____

City, State, Zip_____

I hereby authorize_____

(The office we are requesting information from) to release my entire medical record for transfer of care.

PLEASE FAX RECORDS TO: 984-220-6424

I hereby authorize disclosure of the health information as indicated on this form. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation.

_____ Date_____

Signature of individual

or guardian or Personal Representative of patient's estate

Johanna Sampson, MD
MAGNOLIA MEDICINE
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