LOWCOUNTRY GASTROENTEROLOGY ASSOCIATES, P.A.
MEDICAL CENTER AT EAST COOPER
1300 Hospital Drive, Suite300
Mt. Pleasant, SC 29464
(843)884-5200 Fax (843) 884-6417

Request for the Release of Patient's Medical Records

To: ____
(Physician's Name)

____
(Address)

____
(City, State, Zip)

I hereby request that my medical records be released to:
**All inclusive, unless otherwise specified. **

____
(Physician's Name)

Lowcountry Gastroenterology Associates, P.A.
1300 Hospital Drive, Suite 300
Mt. Pleasant, SC 29464
Office # 843-884-5200
Fax # 843-884-6417

Person, other than patient,
authorized to pick-up records:

Name:___________________________
Date of Birth:______________________

To be completed by the patient or guardian:

Date of Request:________________________________

Patient's Signature:______________________________

Please Print Name:______________________________

Social Security #:_______________________________

Date of Birth:___________________________________