



Medical Records Release Request

Date: _____

TO: _____
Doctor/Physician

Address: _____
City: _____ State: _____ Zip _____
Phone: _____ Fax: _____

I authorize the provider/office listed above to discuss my medical history and/or coordinate my treatment with the office of:

Magnolia Family Dentistry, LLC
Dr. Patricia J. Fast, DMD
1507 A Heritage Lane
Florence, S.C. 29505
Telephone: (843) 665-4477
Fax: (843) 629-0880

Print name of patient

Date of Birth

Signature (patient, parent, guardian)