PEACH TREE MEDICAL CENTER

100 RIDGE MEDICAL PLAZA
SUITE 102
EDGEFIELD, S.C. 29824

PHONE: (803) 637-3630
FAX: (803) 637-5348

AUTHORIZATION OF MEDICAL RELEASE

NAME: _____

DOB: _____ **SS#:** _____

Dear _____

I am writing to authorize Peach Tree Medical Center to obtain my medical records on my behalf. Please release my medical records related to treatment for general care rendered by you or under your supervision from past to present.

If you have any questions, please contact me at _____

Sincerely,

_____
Signature

_____
Date

Name of Medical Facility:_____

Phone #: _____

Fax #: _____