Authorization to Transfer Records

Send to:

1702 Skylyn Drive, Spartanburg, SC 29307

Or

Fax (864)640-8488

Date: _____

Patient Name: _____

Date of Birth: _____

To: Upstate Hand Center; Dr. Sonya M Clark.

I hereby Authorize or make available all the records and reports relating to my case to:

☐ **Dr. Sonya M Clark**
Asheville Orthopedic Associates: Biltmore Park Office
310 Long Shoals Road, Suite 201
Arden, NC. 28704

OR

Name: _____ **M.D./ D.O.**

Address:

Signature: _____