Patient Records Access Request Form

CAROLINA OB/GYN

4017 Hwy 17 Bypass
P.O. Box 3440
Murrells Inlet, SC 29576
(843) 651-6525

1007 N. Fraser St.
Georgetown, SC 29440

I hereby request a copy of my medical record as detailed below:

- ☐ Full medical record held by this office
- ☐ Medical record for the period _____ through _____
- ☐ A specific portion/section of the record as follows:

_____

_____

_____

Reason for request: _____

_____

I understand that, unless otherwise provided by law, the charge for this record will be $0.25 per page for each page copied. I agree to pay this charge in full at the time I receive the copy of the record.

Patient Name:	
Name of Guardian:	Relationship:
Signature:	Date:
Social Security Number:	Phone: