Surgical Associates of Myrtle Beach

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Date: _____

Patient: _____ DOB: _____

I authorize my medical records and any medical information necessary to be released and obtained by Surgical Assoc. of MB to assist in the improvement of my quality of health. I have read and understand the medical release policy of Surgical Assoc. of MB and agree to the above.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature (Employee only) Date