AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

______________________________ ________/________/________
PRINT PATIENT'S FULL NAME BIRTH DATE

______________________________ ________/________/________
STREET ADDRESS HOME PHONE NUMBER

______________________________ ________/________/________
CITY/STATE/ZIP WORK/CELL NUMBER

I, (Patient's Name)______________________________, do hereby authorize the ***Michigan Eyecare Institute*** to **RELEASE/REQUEST** the complete medical record concerning my illness and/or treatment.

RELEASE INFORMATION ***TO/FROM:*** ______________________________
NAME OF DOCTOR/FACILITY/COMPANY/AGENCY/PERSON

____
STREET ADDRESS

____
CITY/STATE/ZIP

(_____)____________ (_____)____________
PHONE NUMBER FAX NUMBER

REASON FOR RELEASE:____

X______________________________________ ______________________________
SIGNATURE OF PATIENT/GUARDIAN DATE

PHYSICIAN'S APPROVAL____________________________________

THIS REQUEST WILL EXPIRE 90 DAYS FROM DATE OF SIGNATURE

Main Office: 29877 Telegraph Rd ● Suite 100 ● Southfield, MI 48034 ● Office (248) 352-2806 ● Fax (248) 352-9590
Branch Offices: 14555 Levan ● Suite E-101 ● Livonia, MI 48154 ● Office (734) 464-7800 ● Fax (734) 464-3612
4337 Maple St ● Dearborn, MI 48126 ● Office (313) 582-7440 ● Fax (313) 582-8090