Release of Medical Record Authorization

PATIENT NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER: _____ BIRTHDATE: _____

NAME OF SPECIALIST: _____

PHONE NUMBER: _____ FAX NUMBER: _____

Permission is hereby given to above named physician or specialist for the release of information pertaining to this patient. Please disclose information and/or copies of my medical records to:

Laurel Women's Medical Group
Joann M. Smith M.D.
36880 Woodward Ave. Suite 201
Bloomfield Hills, MI 48304
Phone: (248) 642-7710
Fax: (248) 642-1443

OR:

Information to be released: _____

_____

_____

_____

_____ _____

Signature of patient, parent or guardian Date