MILLMAN-DERR
CENTER FOR EYE CARE, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name_____ Date of Birth_____

Address_____

RELEASE MY MEDICAL INFORMATION:

I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered to me during the period _____to_____.

RELEASE FROM:

Name_____

Address_____

_____

Phone _____ Fax_____

SEND TO:

Name_____

Address_____

_____

Phone _____ Fax_____

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Signature_____

Witness_____ MR#_____

Records Needed by_____ Pick up_____Fax_____Send_____

PAYMENT METHOD:

Amount Due: $_____ Date Payment Rec'd_____

Type of Payment: CASH CHECK#_____ CHARGE_____

COMPLETED BY_____ DATE_____

375 Barclay Circle, Rochester Hills, MI 48307 (248) 852-3636 FAX (248) 852-3631
17900 23 Mile Rd., Ste. 100, Macomb, MI 48044 (586) 416-1544, (586) 416-1545
30051 Schoenherr, Warren, MI 48088, (586) 558-8800, FAX (586) 558-4771
1 (800) 652-EYES Michigan only