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 of 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 relase of medical records

Signature_____

Records Needed by: _____ Pickup:_____ Fax:_____ Send: _____

Completed By _____

375 Barclay Circle, Rochester Hills, MI 48307 (248) 852-3636 Fax (248) 852-3631

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