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 release of medical records

Signature_____

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

Completed By _____

MILLMAN-DERR CENTER FOR EYE CARE, PC

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17900 23 Mile Rd., Ste.100, Macomb, MI 48044 (586) 416-1544 Fax (586) 416-1545
1(800) 652- EYES Michigan Only