Michigan Ear Institute, P.L.L.C.

REQUEST FOR RECORDS RELEASE

I the undersigned, authorize

NAME: _____

ADDRESS: _____

_____

To release copies of my medical records

From_____ **to** _____
DATE **DATE**

TO:

NAME: _____

ADDRESS: _____

_____

SIGNED: _____
Signature of Patient

DATE: _____

Please print your name and date of birth here:

Please fax form to 248-865-6161

30055 Northwestern Hwy., Suite 101
Farmington Hills, MI 48334

3555 W. Thirteen Mile Road, Suite N-210
Royal Oak, MI 48073

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Novi, MI 48377

(248) 865-4444 FAX: (248) 865-6161