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**REQUEST FOR RECORDS RELEASE**

**I the undersigned, authorize**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**To release copies of my medical records**

from \_\_\_\_\_ thru \_\_\_\_\_  
**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  
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18181 Oakwood Blvd., Suite 402  
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