5250 Auto Club Dr. Suite 200, Dearborn, MI 48126
Phone (313)914-5591 / Fax (313)982-9942

27207 Lahser Rd. Suite 200B, Southfield, MI 48034
Phone (313)914-5591 / Fax (313)982-9942

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name (please print):____

Patient Address:____

____

Date of Birth: ____________________ Phone Number: _____________________

I authorize Metro Detroit Endocrinology Center to release information contained in my medical

records to ____.

Any records released to patients are subject to charge

Specific information to be disclosed: medical records detailing treatment while under such care, including any/all diagnosis of medical conditions, prescribed medication and dosages, medical procedure, etc.

Patient Signature: ____

Date: _________________________

If you are signing as a parent, guardian, or personal representative of the patient listed above, describe the relationship and the source of your authority to sign below.

Print Name: ____________________________________ Date: ____________________

Relationship to Patient:____

Parent / Guardian / Representative Signature: ______________________________________