AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All blanks MUST be filled in)

Patient: ____

Birthdate: ____

Address: ____

____

SSN: ____

Telephone: ____

Released FROM: ______________________

____

____

Released TO: : Keri Topouzian, D.O.
1900 S. Telegraph Rd., Suite 102
Bloomfield Hills, MI 48302
248-302-0473; fax 248-792-0345

Specify type of information to be disclosed:

___ All records ____ Diagnostic reports only ____ Laboratory results only ____ Immunizations

____ Chart notes only ____ Consultations only ____ Other: ______________________________________

Time period: **All Records**

The purpose and need for disclosure:

____ Transfer of Care ____ Attorney Request ____ Disability ____ Workers' Comp ____ Social Security ____ Insurance

____ Other: ____

This authorization

____

Signature of ___ Patient ___ Personal Representative

Printed Name

____

Date

____

If Personal Representative – Relationship to Patient