Michigan Ear Institute

REQUEST FOR RECORDS RELEASE

I the undersigned, authorize

Name of Practice: _____

Address: _____

_____

To release copies of my medical records

From _____ **thru** _____
Date **Date**

To: _____

At:
Michigan Ear Institute
30055 Northwestern Hwy.
Suite 101
Farmington Hills, MI 48334

Patient Name: _____ **DOB:** _____
(Please Print)

Signature: _____ **Date:** _____

Please fax to: (248) 865-6161

Phone: (248) 865-4444 Fax: (248) 865-6161 TDD (248) 865-4191