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Medical Records Release Authorization

Today' Date: _____ Valid Through: _____

Doctor or Hospital: _____

Address: _____

City / State / Zip: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY RECORDS TO:

North Valley Internal Medicine, P.C.
2330 S. Milford Rd. Suite 120
Highland, Michigan 48357
PH: (248) 676-9060
FAX: (248) 684-5550

PLEASE RELEASE THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION,
CONCERNING MY MEDICAL HISTORY, ILLNESS, AND / OR TREATMENT.

Patient Details:

Name: _____ Birth Date: _____

Address: _____

City / State / Zip: _____

Patient's Signature: _____

Witness Signature: _____