18510 MEYERS ROAD
DETROIT, MICHIGAN 48235
PH: 313-474-3040 F: 313-474-4101
INFO@CHUNTERHEALTHCARE.COM

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient's Name:____

Email: ____ Date of Birth: __________________

Please release my medical records from the following physician(s):

Name: ____

Address: ____

City, State, Zip:____

Phone #: ______________________________ Fax #:___________________________

The release of my records is for continuation of care. This document is to expire one (1) year from date of signature.

____ ____________________

Patient Signature Date

Rev 050622