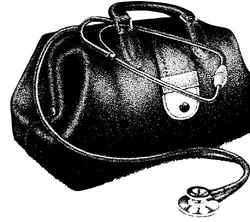
Malcolm Sickels MD P.C.
210 Little Lake Drive, Suite 10
Ann Arbor, MI 48103

Phone 734-332-9936
Fax 734-864-0018



Authorization For Release Of Medical Records

Patient Information (please print):

Name: ____ Date of Birth: ____________

Address: ____

City: ________________________________ State: _______ Zip: ________________

Phone: _______________________________

Please release my medical records from:

Name of office: __________________________________

Telephone: ________________ Fax: ______________________

Address: ____

City: _____________________ State: _______ Zip: __________

Send records to: (Fax preferred)

Malcolm Sickels MD P.C.
Fax: 734-864-0018
210 Little Lake Drive, Suite 10
Ann Arbor, MI 48103

Please send records no later than: _______________

This authorization expires: _______________
Please release a copy of all my medical records, including, but not limited to, progress notes, operative notes, laboratory results, and diagnostic tests unless otherwise specified.

Specific records to include: ____

By my signature, I authorize release of medical records
I understand that I may revoke this authorization in writing at any time, that treatment may not be conditional upon signing this authorization and there is a potential for this information to be re-disclosed by the recipient and no longer protected.

Patient: ____ Date: _________________

-Fill out this form and send it to your previous physician-