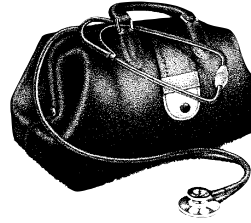


Malcolm Sickels MD P.C.  
210 Little Lake Drive, Suite 10  
Ann Arbor, MI 48103

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:

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

Send records to:

Name of office: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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 us-