

# RECORDS RELEASE AUTHORIZATION

I authorize, \_\_\_\_\_, to release my medical records as identified below to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By initialing the spaces below, I specifically authorize the release of the following information/records, if such information and/or records exist:

\_\_\_\_\_ Please send the entire medical record (all information) to the above named recipient.

\_\_\_\_\_ Records Concerning the Following Condition \_\_\_\_\_

\_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Allergy skin test results

\_\_\_\_\_ Laboratory reports from \_\_\_\_\_

\_\_\_\_\_ Pulmonary Function test reports \_\_\_\_\_ all \_\_\_\_\_ last ( ) year/s \_\_\_\_\_ most recent

\_\_\_\_\_ Sinus/Chest x-ray reports from \_\_\_\_\_ report or film

\_\_\_\_\_ CT scan reports from \_\_\_\_\_ report or film

\_\_\_\_\_ Hospital records needed for continuity of care

\_\_\_\_\_ Other \_\_\_\_\_

Name: \_\_\_\_\_

Asthma & Allergy Institute of Michigan

Jeffrey M. Bruner, D.O. P.C.

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

John Frith, D.O.

Amanda Thomas MS, PA-C

\_\_\_\_\_

42607 Garfield

Date of Birth: \_\_\_\_\_

Clinton Township, MI 48038

(586) 286-9010 (Phone)

Date: \_\_\_\_\_

(586) 286-7910 (Fax)

Signature: \_\_\_\_\_