CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of Birth: _____

I authorize Ophthalmic Specialists of Michigan (formerly Coburn-Kleinfeldt Eye Clinic) to release copies of my medical records to:

Physician Name: _____ Phone Number: _____

Practice Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I authorize release of information for the following portions of my medical record, please specify:

_____ Past number of visits _____ Past year only _____Testing only _____ All records

I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies. I hereby release Ophthalmic Specialists of Michigan from any and all liability which arise as a result of my authorized release of records.

Patient Signature (or legal representative): _____

Date: _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

Processed By (please print): _____ Date: _____

Signature: _____

Patient Charge: _____

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Livonia Office 33400 W. Six Mile Road • Livonia, Michigan 48152 • phone: (734) 421-2020 • fax: (734) 421-2290
Madison Heights Office 301 W. 13 Mile Road • Madison Heights, Michigan 48071 • phone: (248) 268-1079 • fax: (248) 268-3980
Southfield Office 29201 Telegraph Road #101 • Southfield, Michigan 48034 • phone: (248) 861-2020 • fax: (248) 861-2021