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-