RECORD RELEASE

Date:_____

To:_____

_____

_____

_____

I AUTHORIZE AND REQUEST RELEASE OF MY MEDICAL RECORDS TO:

JEFFREY PARKER, M.D.
FOUAD BATAH, M.D.
IZZAT CAROUBA, M.D.
SUSANNA PINELIS, M.D.
29877 Telegraph Rd, Suite 200
Southfield, MI 48034
PHONE: (248) 354-0730 FAX: (248) 354-1652

Complete medical records in your possession concerning my illness and/or treatment during the period from _____ to _____.

SIGNED _____

PRINT _____

SOC SEC _____ WITNESS _____

BIRTHDATE: _____