Ark Multispecialty Physicians, PLLC
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Southfield, MI 48075
Phone: 248-234-6790 Fax: 248-595-8586

Medical Record Release Form

Patient Name: ____Date of Birth: _____________________

By signing this form, I authorize ____ to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician / person / facility/entity listed below.

Name: ____

Address: ____

City: State: Zip code: ____

The purpose/ reason for this release of information is as follows:

____

The information you may release subject to this signed release form is as follows:

☐Complete Records	☐History & Physical	☐Progress notes
☐ Care Plan	☐Lab reports	☐Radiology Reports
☐Pathology Reports	☐Treatment Record	☐Operative Reports
☐Hospital Reports	☐Medication Record	☐Other (please specify below)

_______________________________________ _______________________________________

Patient Name | Signature of Patient or Personal Representative

_______________________________________ _______________________________________

Patient Date of Birth or Social Security Number | Printed Name of Patient or Personal Representative

_______________________________________ _______________________________________

Date | Description of Personal Representatives' authority