COMPEAN
FAMILY MEDICINE

327 Stewart Road
Monroe, MI 48162

734-384-3660 phone
734-384-3661 fax

RELEASE OF PATIENT MEDICAL INFORMATION

Please complete all the sections below to help us correctly process your request to release medical information.
PLEASE PRINT

Patient Name: _____ Date of Birth: _____/_____/_____

Last 4 numbers of Social Security No: _____

I hereby authorize Compean Family Medicine, PLLC to obtain or send medical records as indicated below for the above named patient:

☐ All records	From: _____	To: _____
☐ Immunizations only	From: _____	To: _____
☐ X-ray reports only	From: _____	To: _____
☐ Laboratory tests only	From: _____	To: _____
☐ Other (describe)	From: _____	To: _____

Records are to be obtained **FROM**:

_____
Name

_____
Address

_____
City State Zip Code

_____
Phone# Fax#

and sent **TO**:

_____
Name

_____
Address

_____
City State Zip Code

_____
Phone# Fax#

Signature: _____ Date: _____

Signature from: ☐ Patient ☐ Parent
☐ Authorized Representative** ☐ Legal Guardian**
☐ Personal Representative of the Estate**
☐ Designated Power of Attorney for Health Care** ** please attach required "Letter of Authorization"

Signature Witnessed by: _____ Date: _____

This authorization can be revoked by written request at any time except if Compean Family Medicine, PLLC has already processed this request to release patient medical information. If not previously revoked, this authorization will terminate three months from the date of signature. A photocopy of this authorization will be accepted instead of the original.