Authorization to Release Medical Information

Patient Information:

- **Full Name**:____
- **Date of Birth**:____
- **Address**: ____
- **Phone Number**:____

I hereby authorize:

Name of Healthcare Provider or Facility: ____
Address:____
Phone Number: ____

To release my medical information to:
Name of Recipient: Advanced Breast Surgery, PLLC
Address: 7910 Allen Rd,Suite 101, Allen Park, MI 48101
Phone Number: (313)-648-1212
FAX Number: (313)447-2030

Information to Be Released:

Please release the following medical information (check all that apply)

- ☐ Biopsy Results
  Date Range: From ______________ to ______________
- ☐ Imaging Reports (X-ray, MRI, etc.)
  Date Range: From ______________ to ______________
- ☐ Other (specify:________________________________
- **Date Range**: From ______________ to ______________

Purpose of the Disclosure (check one):

- ☐ Continuation of Care
- ☐ Insurance Purposes
- ☐ Legal Purposes
- ☐ Other (specify): ___________________________________

Acknowledgment and Signature:

I understand that:

- I may revoke this authorization at any time in writing, except to the extent that the provider has already acted on it.
- I am entitled to a copy of this signed authorization.

Patient Signature: ____

Date: ____

Expiration of Authorization:

This authorization will expire 1 year from the date of signature.