Patient Name: _____

Date of Birth: ____/ _____ /_____

Address of Patient: _____

_____

Telephone Number: (_____) _____ - _____

Email Address: _____

Please release my medical records from:

Name of Provider/Practice: _____

Provider's Address: _____

_____

Phone Number: (____) _____ - _____

Fax Number: (____)_____ -_____

If sending records by mail, please send to:
Denali Healthcare
114 S. Center Ave. Ste #103,
Gaylord, MI. 49735

Otherwise, please fax records to: (989) 448-2701

I,_____ ,hereby authorize the release of my medical records to Denali Healthcare.

_____ Date: _____
Patient Signature

Note: Authorization expires six months after signature date.