Obstetrics and Gynecology

Joann M. Smith, M.D.

Release of Medical Record Authorization

PATIENT NAME: ______________________________

ADDRESS: ______________________________

CITY/STATE/ZIP: ______________________________

PHONE NUMBER: ______________ BIRTHDATE: ______________

NAME OF SPECIALIST: ______________________________

PHONE NUMBER: ______________ FAX NUMBER: ______________

Permission is hereby given to above named physician or specialist for the release of information pertaining to this patient. Please disclose information and/or copies of my medical records to:

Laurel Women's Medical Group
Dr. Joann Smith
36880 Woodward Ave. Suite 201
Bloomfield Hills, MI 48304
Phone: (248) 642-7710
Fax: (248) 642-1443

Information to be released: ______________________________

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______________________________ Signature of patient, parent or guardian

______________ Date

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(248) 642-7710 • Fax (248) 642-1443
www.laurelwomensmedicalgroup.com