Dr. Paul Kenzie
108 N Main St
Plymouth, MI 48170

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize Paul Kenzie, OD, to release confidential health information about me by releasing a copy of my medical records, summary, or narrative of my protected health information. This release is valid for one month from date of signature.

Patient Information

Patient Name _____

Date of Birth _____

Street address_____

City _____ State _____ Zip _____

Phone number _____

Email address _____

Records Request Details

Entity to Receive Records

Name _____

Address _____

City _____ State _____ Zip _____

Phone number _____

Patient, Parent or Guardian signature _____

Date _____