TWIN LAKES MEDICAL ASSOCIATES, PC
RELEASE OF INFORMATION FORM

I_____

AUTHORIZE YOU TO SEND THE TEST RESULTS, AND RECORDS REQUESTED. PLEASE FAX OR MAIL TO MY PRIMARY CARE PHYSICIAN:

TED MIKLAS, MD
43700 WOODWARD AVE. SUITE 206
BLOOMFIELD HILLS, MI 48302

PHONE: 248-451-0668

FAX: 248-451-0672

DATE OF BIRTH _____/_____/_____

TODAYS DATE _____/_____/_____

WITNESS SIGNATURE_____

PATIENT SIGNATURE_____