AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

K Steven Wagner M.D.

1500 WALTON BLVD.
ROCHESTER HILLS, MI 48309
TEL (248) 652-6640/ FAX (248) 652-3914

_____ _____
Patient name (print) Date of Birth

___ Patient ___ Parent ___Guardian ____Legal Representative
This Authorization is valid unless expressly revoked by the undersigned

_____
Physician or Facility

__ Entire medical record

__ Portions of the medical record for the period _____ to _____, including:

__ Diagnostic Testing:

___ Lab Work

___Pap Smear

___ Mammogram(s)

___Pelvic Ultrasound

___ Bone Mineral Density

___X-ray ___CT scan ___MRI

___Colonoscopy ___Upper GI endoscopy reports

___ Other_____

__ Office Visit Notes

__ Hospital notes regarding:_____

__ Operative and pathology reports regarding:_____

I authorize the release of medical record information to **K Steven Wagner M.D**. The following release is valid for a maximum of two (2) years from the date of the signature below or until expressly revoked by the undersigned.

_____ _____ _____
Signature of Patient or Patient's Legal Representative | Maiden Name *If applicable* | Date

_____ _____
Witness Date

Updated 3/2018