

Robert Kenewell, DO

1380 Coolidge, Troy, MI 48084

Phone: 888-846-0420 Fax: 248-412-5505

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: Robert Kenewell, DO Fax (248) 412-5505

Address: 1380 Coolidge Rd Suite 101

City: Troy State: MI Zip Code: 48084

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.