Allergy & Asthma Treatment Center, PLC **J. Younes, M.D.**
1251 S Lapeer Road, Suite 102, Lake Orion, MI 48360
Phone: (248) 693-4444

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ _____

I request and authorize
to release health care information of the patient named above to:

Name: **J. Younes, M.D.**
Mail Address: **1251 S Lapeer Road, Suite #102** **Or Fax to: (248) 382-4010**
City: **Lake Orion** State: **MI** Zip Code: **48360**

This request and authorization applies to:

☐ Health care information relating to the following treatment, condition or dates: _____

_____

☐ Other: _____

Patient/ Guardian Signature: _____ Date Signed: _____

Printed Name: _____