R.B. KOLACHALAM M.D.
GENERAL SURERY

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: _____________________R.B. Kolachalam, M.D.________________

Address: _______________26850 Providence Parkway Suite 460_________

City _________Novi____ _____ State ___MI___ Zip Code ___48374____

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 90 DAYS AFTER IT IS SIGNED

26850 Providence Pkwy, Suite 460, Novi, MI 48374 T 248-662-4272 F 248-662-3020
W http://kolachalamsurgery.com/