Melanie Mihlstin, M.D.
5310 Hampton Place, Suite 1 | Saginaw, MI 48604
989-321-2655 | Fax**:** 989-321-2661

Patient Name:_____
Street Address:_____
City:_____ State:_____ Zip code:_____
Phone number:_____ Date of Birth:_____

I authorize MiVision to release copies of my medical records to:

Physician Name:_____ Phone number: _____
Practice Name:_____
Street Address:_____
City:_____ State:_____ Zip code:_____

I authorize the release of information for the following portions of my medical record, please specify:

_____ Last visit _____ Past number of visits _____ Past year only
_____ Testing only _____ All records

I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of already released copies. I hereby release MiVision from any and all liability which arise as a result of my authorized release of records.

Patient Signature (or legal representative):_____
Date:_____ Relationship to patient:_____

FOR OFFICE USE ONLY

Processed by (please print):_____ Date:_____

Signature:_____

Patient charge:_____