

**Allergy & Asthma Treatment Center**  
292 S. Broadway St., Suite 1, Lake Orion, MI 48362  
Phone: (248) 693-4444

J. Younes, M.D.

## 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 \_\_\_\_\_ **Or Fax to: (248) 382-4010**  
Address: **292 S. Broadway St., Suite #1**  
City: **Lake Orion** State: **MI** Zip Code: **48362**

This request and authorization applies to:

Health care information relating to the following treatment, condition or dates: \_\_\_\_\_

All health care information

Other: \_\_\_\_\_

Patient/ Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Printed Name: \_\_\_\_\_