



Clinical Medical Release Form

Medical records cannot be released until this form is completed, signed by the patient or legal guardian, and returned to EHIM:

Patient Name: _____

Patient Date of Birth: _____

Cardholder Name: _____

Cardholder ID #: _____

Cardholder Address, City, State, Zip: _____

Cardholder Telephone #: _____

I hereby authorize the EHIM Clinical Team, acting as an agent of EHIM, Inc. to receive my medical documentation. Please forward my medical records to:

EHIM, Inc.
 Attn: EHIM Clinical Team
 26711 Northwestern Highway, Suite 400
 Southfield, MI 48033
 Ph: 248-948-9900
 Fax: 248-948-9904

This authorization is valid for one year from the date of execution; however, I may revoke it at any time in writing prior to the expiration date. Additional authorization is required for any recipient of my medical records beyond those named above.

Signature of Patient or Legal Guardian

Date

Print Name

Witness Signature