Daniel A. Miller M.D.

1450 South Canfield Niles Road
Austintown, Ohio 44515
Phone: 330-799-8752
Fax: 330-799-8754

RELEASE ANY AND ALL MEDICAL RECORDS FOR:

_____

NAME

_____

ADDRESS

_____

CITY, STATE, ZIP

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____

I HEREBY REQUEST THAT ALL MEDICAL RECORDS BE RELEASED FROM: _____

_____

TELEPHONE: _____ FAX: _____

PLEASE SEND RECORDS TO:

Daniel A. Miller M.D.
1450 South Canfield Niles Road
Austintown, Ohio 44515
Phone: 330-799-8752
Fax: 330-799-8754

_____ _____

AUTHORIZED SIGNATURE **DATE**

_____ _____

WITNESS **DATE**