



Gunateet Goswami, M.D., F.A.C.C.

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Medical Records Request

To:

I hereby authorize you to release to:

**Gunateet Goswami, M.D., F.A.C.C.
43475 Dalcoma Drive, Suite 200
Clinton Township, MI 48038**

any information including the diagnosis and records of any treatment or examination rendered to me as described below:

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.

Print Name

Date of Birth

Signature

Witnessed by

Date

Relationship to Patient (if signed by personal representative of Patient)

EXPIRES ONE YEAR FROM ABOVE DATE