Children's Medical Group of Saginaw Bay, P.L.L.C.

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APPROVAL FOR RELEASE OF MEDICAL INFORMATION

Child:__________________________________ DOB:__________________

Parent or Guardian: ____

I hereby authorize Children's Medical Group of Saginaw Bay, PLLC ('CMG') to provide my child's medical information, subject to any restrictions listed below, to the following person:

Recipient of My Child's Medical Information: _________________________________

I authorize CMG to release the following medical information about my child:

____

____

I authorized CMG to release the above information to the above individual ONLY via the following methods (Please initial):

____ by phone,

when the authorized person calls and provides my child's name and 4 digit PIN:______

____ by fax, to the following number:___________________

____ in person, with valid government-issued identification

____ Patient Portal Email for Non Parent: ____

Patient Portal Access- must check a box in each row!

Appointments	__ Request and View	__View Only	__ No access
Messages	__ Request and View	__ View Only	__ No access
Medications	__ Request and view	__ View Only	__ No access
Health Record	__ Full Access	__ No access	

I agree that this release is valid **until my child reaches the age of 18**. I understand that I may revoke this authorization at any time in writing or by notifying CMG by fax or phone. _____ (initial)

I agree that CMG is not responsible for any further disclosures of my child's medical information made by the recipient of my child's medical information. _____ (initial)

Please sign here:

Parent or Guardian: ______________________________________ Date:____________