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

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I (the parent) _____ authorize Children's Medical Group of Saginaw Bay at the _____Bay City office _____Saginaw office to **release** medical records on (child/children) _____ date of birth:_____

to: _____ at the address of:

_____

_____

_____

Please initial the appropriate box:

_____ any and all medical records

_____ any and all medical records **except** the following: (ex.: HIV status, mental health, alcohol or drug treatment)

_____

This information is being released for the following purpose (not required if records are for own personal use) only:_____

and may **not** be used for any other purpose or released to any other person(s) without my written consent.

Effective Date __ Immediately __ As of (date): _____ (Date chart will be made inactive)

This release is **effective** for six months from the date of signing, however, it may be revoked by me at any time by providing written notice to Children's Medical Group.

Please sign here:

Self or Parent or Guardian: _____ Date:_____

Last 4 SS:_____ Relationship to patient:_____

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