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

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I (the parent/guardian) _____authorize (outside doctor) _____

at the following address: _____

to **release** medical records on (child) _____ date of birth : _____

to the **Children's Medical Group of Saginaw Bay** at the following address: **(please circle which office)**

248 Washington Ave, Ste A
Bay City MI 48708
989-892-5664
989-892-0662 FAX

3875 Bay Rd., Suite 1-S
Saginaw, MI 48603
989-793-9982
989-892-0662 FAX

Jeffrey.vangelderen.p1@direct.cmgsagbay.nextgenshare.com
Robert.thill.p1@direct.cmgsagbay.nextgenshare.com

Please initial the appropriate box:

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

_____

This information is being released for the following purpose only : _____

_____ and may **not** be used for any other purpose or

released to any other person(s) without my written consent.

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 the above named outside doctor.

Please sign here:

Guardian of Patient or Patient **X**_____Date _____

Relationship to Patient _____