

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

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AUTHORIZATION AND CONSENT TO RELEASE AND EXCHANGE MENTAL HEALTH RECORDS WITH A PRIMARY CARE PHYSICIAN

I (the parent) _____ authorize (mental health provider) _____

at the following address: _____ ,

phone number: _____ fax number: _____ ,

to **release** medical records and **exchange information** regarding my mental health treatment and care for coordination of care purposes as may be necessary for the administration and provision of healthcare

coverage on (child) _____ date of birth : _____ .

to the **Children's Medical Group of Saginaw Bay** at the following address:

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

Clinician: _____

Psychiatrist: _____

Presenting Problem including Diagnosis: _____

Medications Prescribed by Mental Health Provider: _____

Additional Comments: _____

This release is **effective** for _____ **OR** one year 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 _____

Date _____

Relationship to Patient _____

Witness to Above Signature _____

Date _____