

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 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/Legal Guardian/Authorized Person: _____

Date: _____ Last 4 SS: _____

Relationship to patient: _____

Bay City Office:
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Bay City MI 48708
(989) 892-5664
(989) 892-0662 FAX