

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

Jeffrey T. VanGelderren, M.D., F.A.A.P.
Hannah Bader, PA-C

Liza Zulauf, FNP-BC
Laurisa Cummings LMSW

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I (the parent/guardian) _____
authorize (outside doctor) _____ at the following phone # _____
to **release** medical records on (child) _____ date of birth : _____

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

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

Jeffrey.vangelderren.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:

Self or Parent/Legal Guardian/Authorized person: _____

Date _____ Relationship to Patient _____