La SHARON SAMUELS, MD, FAAP
PATRICIA BOYST, NP
2240 North Opdyke Road
Auburn Hills, MI 48326
Telephone: 248.289.7400
Facsimile: 248.475.5632

AUTHORIZATION TO RELEASE / OBTAIN MEDICAL RECORDS
Please print. Individual forms are required for each child.

Patient's Last/First Name: ______________________________

M / F Date of Birth: ______________

Current Address: ______________________________

AUTHORIZATION: I authorize my child's information to be released to / obtained from:

Physician / Clinic Name: ______________________________

Address: ______________________________

Phone: ______________________ Fax: ______________________

O Last physical exam and any associated lab work, growth charts, immunization records.
O Other: ______________________________

PURPOSE FOR THE DISCLOSURE: CONTINUITY OF CARE

RECIPIENT: The requested medical record copies should be sent to:

O Country Creek Pediatrics, 2240 North Opdyke Road, Auburn Hills, MI 48326
O Other: ______________________________

This statement must be signed and dated and may be revoked at any time to the extent action has been taken prior to revocation. This consent expires sixty (60) days after the date below, or sooner by choice, in which case this consent will expire on ____________________.

This information is being disclosed to the above named individual/entity for the above stated purpose from records whose confidentiality may be protected by Federal Law.

______________________________ ____________
Signature of Parent / Legal Guardian Date