CONSENT TO RELEASE MEDICAL INFORMATION

Patient:_____

Birthdate:_____

Physician releasing records:

Name:_____

Address:_____

_____

Phone:_____

Fax:_____

Physician to receive records:

Eastman, Wozniak, Groebe Pediatrics, P.C.
2055 E 14 Mile Rd
Birmingham, MI 48009
Phone: 248-645-1740
Fax: 248-645-5304

Medical Information Requested:

__ All records of care from ____ to ____

__ Progress notes and physicals for the past 12 months

__ Laboratory tests

__ Radiology tests

__ Immunizations

__ Other _____

I authorize medical information to be released as indicated above.

I also authorize this information to be sent via FAX transmission.

_____

Signature of Patient, Parent or Guardian Date Phone #