RECORD RELEASE

To: _____
Office Name

_____
Street Name City State Zip

_____
Contact Name Phone Number Fax Number

I, _____, hereby request that you release my child/children's or my own (if over 18) records (growth chart, diagnoses, treatments, lab work/imaging and recommendations) to:

Child Health Associates, P.C.
1800 West Big Beaver
Troy, MI 48084
Ph: 248-205-3535
Fax 248-649-5920

Child Health Associates, P.C.
25500 Meadowbrook, Ste 190
Novi, MI 48375
Ph: 248-788-2100
Fax: 248-513-4144

Date:_____

_____ Patients Name DOB

_____ Patients Name DOB

_____ Patients Name DOB

_____ Patients Name DOB

_____ Patients Name DOB

_____ Patients Name DOB

_____
Parent/Guardian/Self (if over 18) Printed Name **Parent Phone Number**

_____
Parent/Guardian/Self (if over 18) Signature