AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____
(Patient Name) (Date of Birth)

_____ _____
(Street Address) (Phone Number)

_____
(City, State, & Zip Code)

I, _____, do hereby authorize Lakeshore Pediatric
(Patient / Parent or Guardian)

Center to **release** and/or **obtain** all medical records pertaining to _____
(Patient / Date of Birth)

From: _____
(Location)

_____
(Address)

_____
(City, State, & State)

_____
(Signature of Parent or Guardian)

_____ _____
(Date) (Witness)

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