

## RECORDS RELEASE FORM (in)

Name of Patient (s):

Patient(s) Date(s) of Birth:

_____	_____
_____	_____
_____	_____
_____	_____

Physician Releasing Records:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Releasing Records To:

Bloom Pediatrics  
2055 E 14 Mile Road  
Birmingham, MI 48009  
P: 248.645.1740  
Fax: 248.645.5304

I authorize the following to be released via fax/email/mail:

- All records of care from \_\_\_\_\_ to \_\_\_\_\_
- Progress notes and physical exam notes for past 12 months
- Lab tests
- Radiology tests
- Immunization records
- Other
- All of the above

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_

Date: \_\_\_\_\_ Telephone Number: \_\_\_\_\_