Mali&Mali
PEDIATRICS

44344 Dequindre Road, Suite 510
Sterling Heights, Michigan 48314
Phone: 586.323.6300
Fax: 586.323.6331

Consent and Authorization for Release of Records

Patient Name: _____DOB: _____

Phone Number: _____ Date of Request: _____

☐ I authorize _____ to release Medical records **TO** Mali & Mali Pediatrics.

☐ I authorize the custodian of records at Mali & Mali Pediatrics to disclose/release the following information:

- All Records
- Immunization Records
- Other
  (describe)_____

*Only medical records originated through this healthcare facility will be released.

Understand the information in the requested health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and substance abuse.

Please Release Records to (Facility/Physician Name): _____

Address: _____

City: _____State: _____Zip Code: _____

Fax:_____ Phone:_____

The purpose of this request is:

- Change of Insurance
- Change of Physician
- Continuation of Care
- Referral
- Other_____

_____ _____
Patient/Parent/Legal Guardian Relationship to Patient

_____ _____
Signature/Date Witness