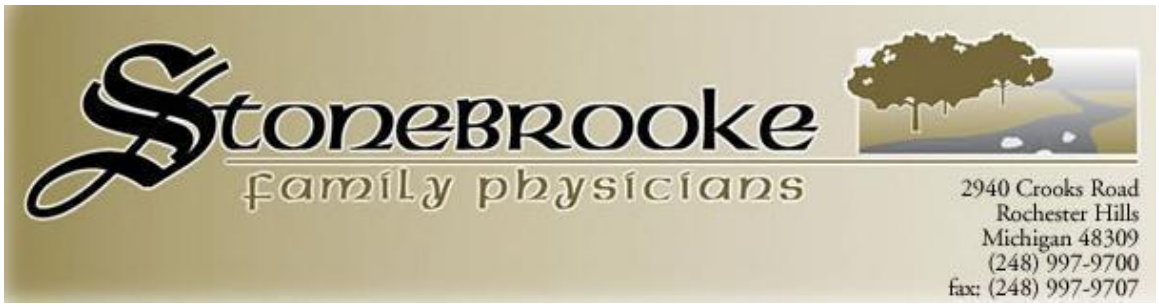

Dr. Ronald Bellisario • Dr. Matthew Ewald • Dr. Stacey Kastl • Dr. Jennifer Haener
Phone: (248)997-9700 • Fax: (248)997-9707

MEDICAL RECORDS REQUEST

PATIENT NAME(S):_____ D.O.B _____
_____ D.O.B _____
_____ D.O.B _____

• NAME AND ADDRESS OF PHYSICIAN TO SEND/OBTAIN RECORDS TO/FROM:

_____

_____

•RECORDS REQUESTED:
_____ All Records
_____ Specific: _____

•RELEASE REASON:
_____ Moving
_____ Transferring to a New Physician
_____ Dissatisfied with: _____
_____ Other: _____

I, _____, hereby authorize Stonebrooke Family Physicians to receive any and all information contained in my medical records.

_____ **DATE: _____**
PATIENT SIGNATURE (PARENT OR GUARDIAN)

The Physicians, Facility, and their employees are released from legal responsibility and/or liability for the release of the above information to the extent indicated and/or authorized here. The recipient of the enclosed information is not authorized to use this patient's medical records for any other purpose than for that stated above and/or to disclose any information from the record to any other person and/or facility without specific written authorization from the patient and/or patient's legal guardian to do so. This authorization is only valid within 90 days of the patient's date of signature on this form. The patient may revoke this authorization at any time except to the extent that the records have already been released pursuant to this release.