DOWNRIVER PEDIATRICS
23050 WEST RD SUITE 110
BROWNSTOWN MI 48183

PATIENT INFORMATION

Date: _____

Name: _____ **DOB:** _____ **Gender:** _____

Address: _____
Street *City* *State* *Zip*

Phone: _____

Access to Medical Records

I authorize the following people listed below to have access to my medical records. This includes, but not limited to, scheduling appointments on my behalf, receiving test results, and discussing my medical history both past and present.

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Signature: _____ **Date:** _____