Release and/or Request of Medical Information

Parent/Guardian name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

Please only release or request relevant medical documentation from/to the following:

Child's Pediatrician & Practice Name: _____

Mother's OB/GYN & Practice Name: _____

Specialist Physician/Practice: _____

Specialist Physician/Practice: _____

Specialist Physician/Practice: _____

Other: _____

Other: _____

Is Milk & Honey authorized to leave detailed phone messages to any of the physicians listed above?
☐ Yes ☐ No

My signature authorizes Milk & Honey LLC to release and/or request medical and treatment information regarding me or my child from the providers and organization listed above.

Signature: _____ Date: _____

Print name: _____

☐ By checking this box, I am acknowledging that I am electronically signing this form.