## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____ to release
(Name of Parent/Guardian) (Name of person or facility which has information)

All medical records in your possession for my child/children:

1._____ DOB: _____

2._____ DOB: _____

3._____ DOB: _____

4._____ DOB: _____

To: Michelle Kolsi MD
110 W. Stocker Street
Glendale, CA. 91202
Office: 818-244-7237
Fax: 818-2446787

For the following purposes:

_____

_____

**Name of Parent/Guardian**: _____

**Patient Address**: _____

_____

**Signature**: _____ **Date**: _____