Milestone Pediatrics
4043 S. RT 59
NAPERVILLE, IL 60564
PHONE: (630) 420-4275 FAX: (630) 420-8957

CONSENT TO RELEASE MEDICAL RECORDS

PATIENT NAME(S):

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

PHONE NO: _____

MEDICAL INFORMATION TO BE SENT:

- ☐ COMPLETE CHART (includes but not limited to HIV, Mental Health and Substance Abuse Information)
- ☐ OFFICE VISIT NOTES
- ☐ VACCINE RECORDS
- ☐ LABORATORY AND/OR X-RAY RESULTS
- ☐ OTHER
- ☐ RECORDS FOR THE DATES FROM _____ TO _____

RECORDS TO BE SENT TO:

NAME: _____ PHONE: _____ FAX:_____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP:_____

REASON FOR REQUEST:

___ I am remaining a patient, but am seeking care from a specialist Physician.
___ Moving out of the area. My new address is: _____.
___ Insurance change. My new insurance is: _____.
___ Other (please list reason):_____.

RECORDS WILL BE:

☐ Picked-up by parent ☐ Faxed (to above number) ☐ Mailed

***THERE IS A $10.00 FEE FOR CHARTS > 10 PAGES, AND A $15.00 FEE FOR CHARTS > 70 PAGES. ANYTHING < 10 PAGES IS FREE OF CHARGE.**

I AUTHORIZE MEDICAL INFORMATION TO BE RELEASED AS INDICATED ABOVE. I UNDERSTAND THIS RELEASE IS EFFECTIVE FOR 1 YEAR FROM THE DATE OF EXECUTION. HOWEVER, I MAY REVOKE MY CONSENT AT ANY TIME BY PROVIDING WRITTEN REVOCATION TO THE ABOVE NAMED PHYSICIAN.

_____ _____
Patient or Patient's Legal Guardian Date

_____ _____
Witness Date