CONSENT TO RECEIVE MEDICAL RECORDS

PHYSICIAN/OFFICE RELEASING RECORDS:

Name: _____

Address: _____

City: _____ State: Z i p : _____

Phone: _____ Fax: _____

RECORDS TO BE SENT TO:

Name: Milestone Pediatrics

Address: 4043 S. Route 59

City: Naperville, IL 60564

Phone: (630) 420-4275 Fax: (630) 420-8957

PATIENT NAME(S):

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

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 _____

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