

CONSENT TO RECEIVE MEDICAL RECORDS

Physician/Office Releasing Records:

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Records to be sent to:

Milestone Pediatrics Phone: (630) 420-4275
4043 S. Route 59 Fax: (630) 420-8957
Naperville, IL 60564

If records are being faxed and are <10 pages please fax vaccine records and mail remaining records.

Patient Name(s)

_____ D.O.B. _____
_____ D.O.B. _____
_____ D.O.B. _____
_____ D.O.B. _____

Medical Information to be sent:

- ☐ Complete chart (includes but not limited to HIV, Mental Health and Substance Abuse Information)
☐ Office Notes
☐ Vaccine Records
☐ Laboratory and/or X-Rays results
☐ Other
☐ Records for the dates from _____ to _____
☐ Records required to transfer care (Vaccine record, Growth charts and last Office Visit)

I Authorize medical information to be released as indicated above. I understand this release is effective for one year from the date of execution. However, I may revoke my consent at any time
By providing written revocation to the above named physician.

Parent Signature: _____ Date _____
Patient's Signature: (12-17 must sign) _____ Date _____
Witness Signature: _____ Date _____