# Milestones Pediatric

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## Authorization to Release Medical Records

Name of Patient: _____ DOB: _____

Parent/Guardian Name: _____

Phone Number _____ Email: _____

**Release Records To:**

Name /Facility _____

Address _____

Phone: _____ Fax: _____

**Information to be Released:**

- Complete Medical Record
- Immunization records
- Lab Reports
- Radiology Reports
- Visit Summaries
- Other

**Purpose of Disclosure**

- Transferring to another doctor
- Continuation of Care

- Personal Use
- Insurance
- Legal Purposes
- Social Security /Disability
- Other: _____

Authorizations

I authorize the release of the specified medical records of the above–named patient. I understand that I may revoke this authorization in writing at any time. I understand that I may be charged a processing fee for copies of my medical records

Signature of Parent/Guardian: _____

Printed Name: _____

Relationship to Patient _____

Date: _____