Milestones Pediatric Clinic

Authorization For Release of Medical Information

Patient Name _____ Date of Birth _____

Phone _____

Address _____ City, State, Zip: _____

I hereby authorize the release of my child's medical records from:

Name of previous clinic _____

Address_____ City/State /Zip_____

Phone_____ Fax_____

To

Milestones Pediatric Clinic

3951 Alma Rd, Suite # 402

Mckinney, Texas 75070

Phone :469-678-8204, Fax:469-625-2883

Contact@milestones-pediatric.com

Information to be released is as follows:

◯**Full medical Record**

◯**Newborn nursery hospital records**

◯**Immunization Record Only**

◯**Other (please specify):**

Parent/ Guardian Signature: _____ Date _____

Parent/Guardian Name _____