

*Milestone Pediatrics, P.C.*

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MEDICAL RECORDS RELEASE

I, \_\_\_\_\_ authorize the release of  
my medical records from \_\_\_\_\_ for  
patient \_\_\_\_\_, date of birth  
\_\_\_\_/\_\_\_\_/\_\_\_\_.

Please send copies of my medical records to :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you,

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date