Patient Name: ____________________________
Date of Birth: ____________________________

MEDICAL RECORDS RELEASE

I, ____, ______________________ authorize the release of my
(Patient Name) *(Date of Birth)*
medical records from Milestone Pediatrics.

Please send copies of the following types of records:

- ☐ Most recent office note
- ☐ Most recent well visit
- ☐ Lab results
- ☐ Radiology results
- ☐ Cardiovascular testing
- ☐ Surgical history
- ☐ Other: ___________________________________

Please send copies of my medical records to:

Address: ________________________________
____
____

Phone: ________________________________

Fax: ________________________________

Thank you.

____
(Patient Signature)

____
(Parent/Guardian Signature)

____
(Date)

Milestone Pediatrics
20611 Watertown Road, Suite D
Waukesha, WI 53186
Phone: (262) 256-0676
Fax: (262) 205-4210