Patient Name: ______________________
Date of Birth: ______________________

MEDICAL RECORDS RELEASE

I, ____________________________________, __________________ authorize the release of my
(Patient Name) *(Date of Birth)*
medical records to 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:
Milestone Pediatrics SC
20611 Watertown Road, Suite D
Waukesha, WI 53186

Phone: 262-256-0676

Fax: 262-330-8734

Thank you.

____
(Parent/Guardian Signature)

____
(Date)

Milestone Pediatrics
20611 Watertown Road, Suite D
Waukesha, WI 53186
Phone: (262) 256-0676
Fax: (262) 330-8734