Milestone Pediatrics
20400 Observation Drive Suite 205
Germantown, MD 20876
301-972-9559 301-972-9593 (Fax)

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

_____ (Patient Full Name)

_____ (Birth Date)

_____ (Street Address)

_____ (Social Security Number)

_____ (City, State, Zip)

_____ (Phone Number)

I hereby authorize Milestone Pediatrics to release the following medical information to:
(Name of Practice or Provider)

_____
(Facility or Provider Name)

_____
(Address)

_____
(Phone Number) (Fax Number)

___ ALL RECORDS

Records for the following date of Service: _____*(please check all that apply)*

___ History & Physical ___ Office Notes ___ Radiology Reports
___ Laboratory Reports ___ Immunizations

Purpose of Disclosure:

___ Change of Doctor ___ Moved ___ Other *(please specify)*
_____

Authorization is to: ___ Continue indefinitely ___ Expire as of _____

I understand that this authorization can be revoked at any time with written notification to the practice.
I also understand that there may be a charge for a personal copy or permanent transfer of my records.

_____ _____
(Signature of Patient , Parent/Guardian, or Patient's Personal Representative) (Date)