REQUEST FOR MEDICAL RECORDS

With this form, you authorize the release of your medical health information.
Print neatly and complete all fields.

Patient's Last Name, First Name, DOB (mm/dd/yyy) **Child #1**_____**Child #2**_____ **Child #3**_____ **Child 4**_____ **Child #5**_____ **Child #6**_____			
Address	**City**	**State**	**Zip**
Phone #			

IDENTIFY THE FACILITY OR PRESON YOU ARE RELEASING YOUR MEDICAL INFORMATION TO.

Milestones Pediatrics LLC 11 East Oak St. Oakland, NJ 07436 Phone: (201) 485-7557 Fax: (201) 485-7556	is sending information to	Name of facility or person: Address: Phone: Fax:

SPECIFY THE INFORMATION TO BE RELEASED

Why do you want the information to be released? _____ For which dates of service do you want medical records released? _____ What categories of information do you wish to have included: ☐ Immunization records and health history only ☐ All medical records **except sensitive documents** (substance or alcohol abuse, domestic violence, sexual assault, HIV related) ☐ All medical records, **including sensitive documents** ☐ All medical records, **except** medical records from other facilities ☐ Other (please specify in writing here what records you are requesting): _____	On what day do you wish this consent to expire? _____ (mm/dd/yyyy) *In order to protect your medical records information, this consent must have a time limit; you are not permitted to grant consent that does not expire. Timeframe cannot exceed one year from date of signature below.* ***If left blank, consent expires 90 days after signature date.*** *You may terminate this consent at any time by sending a written request to the facility/person identified above to release records. Receipt of a termination request will cancel future actions, but cannot reverse the release of information already completed.*

Please be aware that there is a charge for records.

- $ 1.00 per page or $ 100.00 for the entire record, whichever is less.
- If the record requested is less than 10 pages, the licensee may charge up to $ 10.00 to cover postage and the miscellaneous costs associated with retrieval of the record.

CERTIFY THIS REQUEST

_____

Patient's Signature (or Legal Guardian's if patient is <18) Print Name Date Signed (mm/dd/yyyy)

Relationship to patient (circle one): self parent legal guardian