Millcreek Pediatrics Records Transfer Request

A form for each child must be completed. All records will be copied to a CD and mailed. There is a fee for transferring records.

I hereby authorize:

Millcreek Pediatrics
2055 Limestone Rd Ste 300
Wilmington, DE 19808
Ph: 302-633-6338
Fax: 302-633-9398

___ Albert Macfarlane, MD
___ Jenna Seiff, MD
___ Joanna Graeber, DO

To release information to: _____

Address: _____

City/Zip: _____

Ph/Fax: _____

Information requested:

Name of Child: _____

Date of Birth: _____

Address: _____

City/Zip: _____

Phone: _____

Mother's name: _____

Father's name: _____

Date of treatment: From: _____ To: _____

Reason for transfer of records: _____

(Check information that may be released. Please note only records that have been ordered by our office may be released)

- ○ History/Physical exam
- ○ Discharge Summary
- ○ Consultation Reports
- ○ Laboratory Reports
- ○ Psychological/Education Reports
- ○ Operative Reports
- ○ Immunization Records
- ○ Progress Note(s)
- ○ Other _____

I understand this authorization is only valid for ***60 days*** from the date of signature. I understand I may revoke this consent at any time but not retroactive to the release made in good faith.

Patient or Adult legally responsible: _____ Date: _____

Witness (for office staff): _____Date: _____