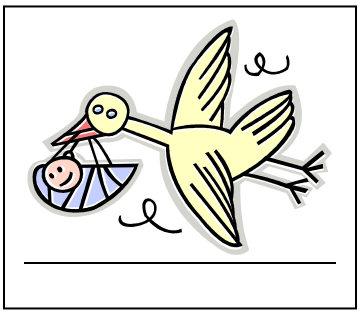
Millcreek Pediatrics Records Request



I hereby authorize: Physician: _____

Address: _____

City/ Zip: _____

Phone/Fax: _____

To release the information to: Millcreek Pediatrics
4512 Kirkwood Hwy. Suite 201
Wilmington, DE 19808
Ph: (302) 633-6338
Fax: (302) 633-9398

___ Albert Macfarlane, MD
___ Carla Morris-Taylor, MD
___ Andrea Marvin, MD
___ Jenna Seiff, MD

Information requested:

Name of Child: _____

Date of Birth: _____

Address: _____

City/Zip: _____

Phone: _____

Father's Name: _____

Mother's Name: _____

Date of treatment: From: _____ To: _____

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

- o History/Physical exam
- o Discharge Summary
- o Consultation Reports
- o Operative Reports
- o Laboratory Reports
- o Medical Imaging
- o Psychological/Education reports
- o Immunization Records
- o Progress Note(s)
- o 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: _____

For office use:

Date Record Request Sent _____/_____/_____ Staff Initial: _____
Via Mail or Fax (attach fax transmission sheet)