Millcreek Pediatrics Records Transfer Request

A form for each child must be completed.

I hereby authorize: _____

Address: _____

City/Zip: _____

Ph/Fax: _____

To release information to:
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 Shaffer, MD

Information requested:

Name of Child: _____

Date of Birth: _____

Address: _____

City/Zip: _____

Phone: _____

Mother's name: _____

Father's name: _____

Date of treatment: From: _____ To: _____

- 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: _____

For office use only:
Date request sent: _____ /_____ /_____
Staff initial:_____
Via mail or Fax (If faxed attach fax transmission sheet)