MILLBURN PEDIATRICS
159 MILLBURN AVE
MILLBURN, NJ 07041
Phone: 973-912-0155 Fax: 973-912-8714

Date:___________________________

I, _________________________________, hereby request the release of the complete medical records for my child/children:

____

I understand that there is a $1.00 per page coping fee; not to exceed $50.00 per child. Records will not be released until coping fee is received. If records are to be mailed, payment must be made prior to being copied.

Please note: Medical records cannot be faxed. Original copies remain the property of Millburn Pediatrics.

( ) Please mail my child/children's records to:
(add'l $5.00 handling fee per chart)

____

____

( ) I will pick up.

____
Name

____
Address

____
City, State, Zip

____
Phone