11050 Crabapple Rd
Suite 120
Roswell, GA 30075
P: (770) 518-9277
F: (770) 518-8718

1111 Alderman Dr
Suite 250
Alpharetta, GA 30005
P: (678) 527-1555
F: (678) 527-1559

Pediatric Physicians

Medical Records Request

REQUEST FOR MEDICAL RECORDS FROM ANOTHER OFFICE WITH PATIENT AUTHORIZATION

Records requested from: (Name and Address of Doctor, Hospital or Medical Facility)

_____ P: _____
_____ F:_____
_____

Release information to: Please release medical record information to Pediatric Physicians:

☐ 11050 Crabapple Road
Suite 120
Roswell, GA 30075
(770) 518-9277
(770) 518-8718 fax

☐ 1111 Alderman Drive
Suite 250
Alpharetta, GA 30005
(678) 527-1555
(678) 527-1559 fax

***** Please fax immunization record, growth charts, and problem list ONLY. Thank you. *****

Or: Specific record request: _____
_____

Purpose for requesting records: □ Moved □ Change of Insurance □ Legal □ Personal

Request is for:

Patient Name: _____ DOB:____/_____/_____
Patient Name: _____ DOB:____/_____/_____
Patient Name: _____ DOB:____/_____/_____
Patient Name: _____ DOB:____/_____/_____

****

My signature below serves as an authorization to release the above information to the named party. I understand that these records may include psychiatric, chemical and substance abuse, HIV, and AIDS information and that I may withdraw in writing this authorization at any time, except to the extent that action has been taken based on this authorization.

Signature: _____ Date: _____/_____/_____
(expires 90 days from date signed)

Name (please print) _____ Phone#_____

Relationship to patient: □ Parent □ Self (18+) □ Other Guardian

If Other Guardian, please specify relationship _____

Date Signed: _____ Expiration Date: _____