



105 Collier Road Suite 4060 Atlanta, Georgia 30309 404.351.6662 f 404.351.6030 www.piedmontpediatrics.org

Release of Medical Records From Piedmont Pediatrics Request Form

Information Requested:

Standard Transfer Records (growth chart, immunization records, and copy last physical)

Additional Records* please list: _____

The purpose of requesting medical records:

Changing Practices/Moving Personal Use Continuation of Care/Internist Transfer Legal/Attorney

Other(specify): _____

I hereby authorize Piedmont Pediatrics to release health records of:

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

I hereby Authorize Piedmont Pediatrics to release the medical records by means of the following method(s)

***please make no more than two selections**:*

Email: _____

Pick-Up: _____

Name and Number of whom to contact when records are ready for pick-up

Fax: _____

Practice/Person Name & Fax Number (include ATTN if necessary)

Mail: _____

Person/Practice Name & Address

X
Signature of Patient (If over 18), Parent, or Legal Representative

_____ Date

Printed Name of Person submitting this request

By signing this form, you authorize Piedmont Pediatrics to release medical records for the above patient(s) by means of the selected release methods. The request notated on this form is effective for one (1) year from the signature date unless written revocation is submitted. Any patient under the age of eighteen (18) years of age must obtain a parent/guardian signature. Please allow at least seven to ten business days for records to be released.