PIEDMONT PEDIATRICS

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

Request of Medical Records Release to Piedmont Pediatrics

Request Form

Health Information Requested:

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

☐ **Additional Records*** please list: _____

Healthcare provider or practice Piedmont Pediatrics is requesting records from:

Practice/Provider Name:_____

Address:_____**City:**_____**State:**_____**ZIP:**_____

Phone:(_____)_____**Fax:(_____)**_____

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

Piedmont Pediatrics

105 Collier Road Suite 4060 Atlanta, Georgia 30309

Ph:404.351.6662 || Fx: 404.793.0477 || medical.records@piedmontpediatrics.org

X_____ _____

Signature of Patient **(if over 18)**, Parent, or Legal Representative — Date

_____

Printed Name of Person submitting this request **AND** relationship to patient

By signing this form, you authorize Piedmont Pediatrics to request the release of medical records for the above patient(s). 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.