REQUEST FOR RELEASE OF MEDICAL INFORMATION

RELEASE FROM:

Peachtree Park Pediatrics, LLP
3193 Howell Mill Road
Suite 250
Atlanta, GA 30327
Phone (404)351-1131 • Fax (404)351-3515

RELEASE TO:

_____
Name

_____
Address

_____
City State ZIP Code

_____
Phone **FAX (required)**

PLEASE NOTE: A $10 fee applies to medical records released to a parent/guardian, while medical records sent directly to another physician's office is free of charge.

Please release records on the following patient(s)

1. _____ Date of Birth_____
2. _____ Date of Birth_____
3. _____ Date of Birth_____

Reason for Request: _____Change in Insurance
_____Moving out of area
_____Other (please explain) _____
_____

I understand that this medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that the information I disclose may no longer be protected by federal or state law, except for drug and alcohol treatment information.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

Thank you.