Request to Transfer Medical Records from Center for Pediatric Wellness

Fax completed form to 470-655-1002 I Questions? Call 470-655-1001

Please transfer the medical records for the following children:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Current address: _____ City: _____ State: _____ Zip: _____

Future address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (day) _____ (evening)

I, _____, do hereby authorize Center for Pediatric Wellness to release:
Parent name if <18 years, patient name if >18 years

Please check one or both

□ All medical records pertaining to the care and treatment received at Center for Pediatric Wellness.

□ I do □ I do NOT authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

Rease for records release or copy

□ Personal copy □ Over age 19 □ Insurance change □ Moving/changing providers

□ Referral to specialists □ Unhappy with practice, explain: _____

□ Other: _____

This authorization permits:

Center for Pediatric Wellness to release records to: _____
6000 Lake Forrest Drive NW _____
Suite 110 _____
Atlanta, GA 30328 _____

□ I prefer to pick up my record rather than having it mailed. Please call when ready.

The signature below serves as authorization to transfer records:

_____
Parent if patient is <18 years, patient if >18 years