

**RELEASE OF MEDICAL RECORDS**

**I request that:**

(Designates physician, person or entity) \_\_\_\_\_

(Address) \_\_\_\_\_

(City) (State)(Zip) \_\_\_\_\_

(Telephone) (Fax) \_\_\_\_\_

release the **COMPLETE MEDICAL RECORDS AND IMMUNIZATIONS** of the following patients:

(Please list the full names of all children whom you are requesting records for)

1. \_\_\_\_\_ DOB \_\_\_\_\_

2. \_\_\_\_\_ DOB \_\_\_\_\_

3. \_\_\_\_\_ DOB \_\_\_\_\_

4. \_\_\_\_\_ DOB \_\_\_\_\_

5. \_\_\_\_\_ DOB \_\_\_\_\_

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[webtriage@atlchildrens.com](mailto:webtriage@atlchildrens.com)

**Circle PCP Selection:** Dr. Megan Ference, MD or Dr. Reshma Chugani, MD

Date \_\_\_\_\_

Signature \_\_\_\_\_

(If minor, signature of parent, guardian, or custodian)

Print name \_\_\_\_\_

**\*\*\*This office will not schedule any new patient appointments until complete medical records are received from the previous physician's office for coordination of care, we are not contracted with any Medicaid insurance policies (Ex. CareSource, Peachstate, Amerigroup, etc.) Please confirm that we accept your insurance\*\*\***

*Internal use only.*

*Date Received:*

*Initials:*