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__________________

Atlanta Children's Clinical Center, P.C.
455 East Paces Ferry Road, Suite 212
Atlanta, GA 30305
Phone(404) 261-2666 / Fax (404) 261-2669
webtriage@atlchildrens.com

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

Date________________________

Signature____ Print name ______________________________
(If minor, signature of parent, guardian, or custodian)

Phone#_________________ Email Address:_________________________________

*****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 before transfer of records*****

(Internal use only) Date Received:____________ Initials:_____________