RELEASE OF MEDICAL RECORDS

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]

I request that **Atlanta Children's Clinical Center, P.C.,** release the medical records and immunization dates 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_____

To:

(Designates physician, person, or entity)_____

(Address)_____

(City)(State)(Zip)_____

(Telephone)(Fax)_____

Transferring out? Yes or No (circle one) Moving? Yes or No (circle one)

Date_____

Signature_____

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

Print Name_____

Internal use only

*Date received:*_____ *Initials:*_____ *Date Processed:*_____ *Initials:*_____

*Physician Approval:*_____ *Date:*_____ *Cost:*_____