FORM A

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Medical records can be mailed or picked up

I hereby authorize the release of my medical records:

Records Requested for:

Patient's Full Name: ________________________________

DOB: _____________

Male___ Female___

Records From: All About Kids Pediatrics

2000 Riverside Parkway, Suite 207

Lawrenceville, Georgia 30043

To: (Name of Practice) ____

Physician: ____

Address: ____

Phone: _________________ Fax: _________________

Parents Signature: _______________________________

Parents Printed Name: __________________________

Phone Number: ________________________

Date: _________

I understand a fee of $15 per child up to 2 and $35 for 3 or more children will be charged for records that I wish to pick up or have mailed directly to me. This fee is based on the Georgia Health Information Medical Association guidelines. These fees are due prior to medical records being copied. I also understand that I am responsible for any remaining balance on my account that has been determined to be patient responsibility.

Parent/Guardian's Signature: _______________________________ Date: ________________

Amount Due: $ ________ Payment Method: _____ Cash _____ Check # _____ Credit Card