All About Kids Pediatrics

Jill Overcash, MD, FAAP
Amanda Bennett, CPNP
2000 Riverside Parkway, Suite 207
Lawrenceville, GA 30043
Phone 678-646-0404
Fax 678-646-0202
www.allaboutkidsgeorgia.com

Medical Records Request Form A

I hereby authorize the release of my medical records from All About Kids Pediatrics. Please release records for:

Patient's Full Name: ________________________

Date of Birth: _______________________

Dates Requested: __________________________ to _________________________

Requesting records to be sent to:

Name of Practice (Doctor): _______________________________________

Address: ____

City: _______________________________ State: _______________________ Zip: _________________

Phone: ____________________________

Fax: ______________________________________

Medical records can be picked up in the office by a parent or mailed directly to another practice. We cannot fax any record that is more than 20 pages. There is a fee of $15 per child but a flat fee of $30 for 2 or more patients. This fee is based on the Georgia Health Information Medical Association guidelines. These fees are due prior to medical records being copied. Please note that once a medical record request has been processed the patient is then dismissed from the practice. At this time, the guarantor accepts financial responsibility for any remaining balance on the patient's account.

___________________________________ ____________________________

Parent/Legal Guardian Signature Date

___________________________________ ____________________________

Printed Name Phone Number

Amount Due: __________ Payment Method: _____________ Cash __________ Check _________ Card

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