All About Kids Pediatrics

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Medical Records Request Form

***Section A:** Obtaining records from another Physician or Medical Office

***Section B:** Sending records to another Physician or Medical Office

Section A:

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

Patient's Full Name: _____ Date of Birth:_____

- ☐ Full Records
- ☐ Last Visit

Requesting Records From:

Name of Practice (Doctor):_____ Address:_____

Phone: _____ Fax:_____

Section B:

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:_____

- ☐ Full Records
- ☐ Last Visit

Requesting records to be sent to:

Name of Practice (Doctor):_____ Address:_____

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. Currently, the guarantor accepts financial responsibility for any remaining balance on the patient's account.

_____ _____

Parent/Legal Guardian Signature Date

Amount Due: _____ Payment Method: _____ Cash _____ Check _____ Card

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