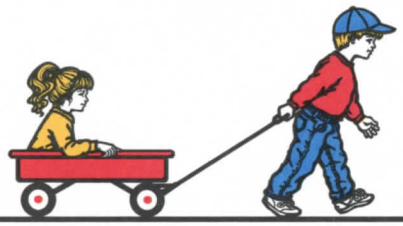

Pediatric Associates of Johns Creek, P.C.

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CONSENT TO RELEASE MEDICAL RECORDS FROM PAJC

I DO HERBY AUTHORIZE PEDIATRIC ASSOCIATES OF JOHNS CREEK TO RELEASE RECORDS FOR THE FOLLOWING PATIENTS:

Patient Name: _____ DOB: ____/____/_____

Patient Name: _____ DOB: ____/____/_____

Patient Name: _____ DOB: ____/____/_____

Patient Name: _____ DOB: ____/____/_____

AT THIS TIME, I WOULD LIKE TO REQUEST THE FOLLOWING :

- o BASICS [immunization record, growth chart, summary of encounters, & copy of last check-up]
- o ENTIRE CHART [$30 COPYING FEE/FAMILY]
- o OTHER _____

REASON FOR REQUESTING RECORDS:

- o PERSONAL COPY
- o COPY FOR SPECIALIST
- o TRANSFERRING FROM PRACTICE
  - o Moving
  - o Adult/Family MD
  - o Other _____

PLEASE FORWARD THE INDICATED MEDICAL RECORDS TO:

- o IN OFFICE PICK-UP [please allow 5 business days]
- o MAILED: Address: _____

  _____

  _____
- o FAXED: Fax #: _____

PRINT PARENT/PATIENT (18+YEARS OLD) NAME: _____ DATE: ____/____/_____

PARENT/PATIENT (18+YEARS OLD) SIGNATURE: _____

PHONE NUMBER: _____

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