Pediatric Associates
of
Johns Creek

KARA L. BARLOW, M.D., F.A.A.P. AARON M. WORTH, M.D., F.A.A.P

AMY KO, D.O., F.A.A.P. QADARA BEYAH, C.P.N.P.-P.C.

CONSENT TO RELEASE MEDICAL RECORDS FROM PAJC

I DO HERBY AUTHORIZE THE RELEASE OF 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 :

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

REASON FOR REQUESTING RECORDS:

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

PLEASE FORWARD THE INDICATED MEDICAL RECORDS TO:

- IN OFFICE PICK-UP [PLEASE ALLOW 5-7 BUSINESS DAYS]
- MAILED: Address: _____
  _____
  _____
- FAXED: Fax #: _____

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

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

PHONE NUMBER: _____