Pediatric Associates
of
Johns Creek

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CONSENT TO RELEASE MEDICAL RECORDS TO 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: ____/____/_____

PREVIOUS DOCTOR'S INFORMATION:
NAME OF PRACTICE: _____
PHONE: _____ **FAX:** _____

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 [previous MD may have a copying fee]
- OTHER _____

REASON FOR REQUESTING RECORDS:

- RECORDS FROM ER/URGENT CARE VISIT FOR CONTINUATION OF CARE: Date(s) of Service _____
- RECORDS FROM SPECIALIST FOR CONTINUATION OF CARE: Date(s) of Service _____
- TRANSFERRING FROM PRACTICE
  - Moved
  - New Pediatrician
  - Other _____

PLEASE FORWARD THE INDICATED MEDICAL RECORDS TO:

- MAILED: Address: **PEDIATRIC ASSOCIATES OF JOHNS CREEK**
  4310 JOHNS CREEK PARKWAY, SUITE 150
  SUWANEE, GEORGIA 30024
- FAXED: Fax #: **770-476-1674**
  Phone #: **770-476-4020**

PRINT PARENT/PATIENT (18+YEARS OLD) NAME: _____ DATE: ____/____/_____
PARENT/PATIENT (18+YEARS OLD) **SIGNATURE:** _____
PHONE NUMBER: _____