



Roswell Pediatric Center, P.C.

Request for Release of Medical Records From Roswell Pediatric Center

I hereby authorize Roswell Pediatric Center, P.C. to release the records of:

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

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Patient's Name: _____ DOB: _____

Type of records to be released:

Medical Records (includes growth charts, last check up, last three office visits, & immunizations if not specified)

Billing Records Form Other (specify): _____

Forwarding instructions of requested records:

Fax to: _____ Contact #: _____

Office Pick up: Old Milton Pkwy / Crabapple / Cumming Date: _____
(Please allow 10 business days for medical records)

Mail to: _____

Name of Practice/Person & Address

Purpose for requesting medical records:

Moving Insurance Change Transferring to adult doctor Personal Legal/Attorney

Other (specify): _____

A valid photo ID, of the legal guardian/patient (18yrs/+) who signed this release, is required for release of medical records.

One paper copy of your child's records will be provided free of charge. However, a fee may apply if copies of entire medical records are requested. Any request thereafter may be subject to charge.

Signature of Legal Guardian/Patient (18yrs/+)

Date