416 Pirkle Ferry Road,
Suite J300 Cumming, GA 30040
(770) 889-9142 office (770) 889-7151 fax

Record Release

From Georgetown Pediatrics to new provider

Name of Patient **Date of Birth**

_____

_____

_____

_____

Reason for Transferring Out of Georgetown Pediatrics: _____

☐ **Not transferring out of practice. Reason records requested:** _____

Patient Home Address: _____

Release Records To:

Provider/Practice: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Transferring out, or any Georgetown record request:

I authorize Georgetown Pediatrics, PC to release my medical records as requested above. **I understand there will be a $25.00 record fee for each child listed, for a complete copy of medical records (not including records originating from other medical facilities).** I understand that I may be given a copy of my child(s) immunizations (3231) and/or hearing and vision (3300) at no charge. Please be advised a signature is required for ALL records requested. Once you transfer out of Georgetown Pediatrics, P.C., the records will be transferred to an off-site storage facility. If records are requested once transition has been made, it may take up to 30 days for us to retrieve the records from the facility and an additional charge will be assessed). We recommend that we mail your records to your home address so you may make a copy before providing them to your new physician. **By law your new physician is unable to release our records to you. If you are 18 years or older you must sign for your own records.**

If you prefer to have all records mailed to you directly, mark the box below:

☐ I would prefer to have my records mailed to the following address. **I have paid the records fee:**

_____Phone: _____

Signature: ***(Valid Driver's License will be requested from parent or guardian BEFORE release of any medical records)***

X_____ **X**_____

Signature of Parent/Guardian or Patient (18 or older) Date completed by: (Georgetown Employee Signature) Date