Record Release

Name of Patient _____ **Date of Birth**_____

_____

_____

_____

_____

Please mark the box of the type of records you are requesting:

☐ All Medical Records ☐ Billing Records ☐ Other: (Please specify) _____

Reason for requesting records:

☐ **Transferring to** Georgetown Pediatrics, PC ☐ Transferring to Adult Doctor

☐ Moving ☐ Not Satisfied: **Transferring out** (***Please Specify Reason***) _____

Becoming a Georgetown Pediatrics, PC Patient?

If transferring to Georgetown Pediatrics, please provide previous PCP information below:

Name of Practice _____**Phone #**_____**Fax#**_____

Address _____ **City** _____ **State**_____ **Zip**_____

Transferring out or a 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.**

How would you records delivered?

☐ Fax: _____ (charts over 50 pages cannot be faxed)

☐ I would like to pick-up my records at: ☐ Cumming ☐ Johns Creek

☐ I would prefer to have my records mailed to the following address: _____

_____

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

_____ _____

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

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

6300 Hospital Parkway
Suite 125
Johns Creek, GA 30097
(770) 814-8883 office
(770) 814 8162 fax