



3745 Cherokee Street, Suite 401 - Kennesaw, GA 30144
 770 429 1005 Phone
 www.kennesawpediatrics.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name		DOB	
Patient's Name		DOB	
Patient's Name		DOB	
Patient's Name		DOB	
Patient's Current Address:			
Patient's Previous Address:			
Patient's Current Phone #:			

INFORMATION TO BE RELEASED

Immunization/Growth Chart Only *3231 Form* *Day Care Form*
 Complete Medical Records
 (\$20.00 Fee Due Prior To Delivery of Request) *3300 Form* *Sports Forms*

REASON FOR REQUEST

Personal Records **Specialist/Referral** **School** **Insurance** **Legal**
 Transferring Out
Transferring Reason: **Relocation** **Change Insurance** **Unhappy with Staff/Practice**
 Other: _____

DELIVERY OF RECORDS

Pick Up In Person **Via Regular Mail** **Fax : () _____**

RELEASE INFORMATION TO

NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:

***By signing below, I understand that (1) I release Kennesaw Pediatrics and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damage, which may result from the release of information authorized by this Consent for Release of Medical Information; (2) this consent is valid from the date signed and continues until I revoke this authorization by giving Kennesaw Pediatrics written notice; (3) I may revoke this authorization at any time, unless the action has already been taken utilizing this signed consent or it the authorization was obtained as a condition of obtaining insurance coverage; (4) the practice will not condition treatment or payment based on my signing this authorization; (5) I am signing this authorization freely; (6) no one has pressured me to sign this authorization; (7) I acknowledge that I've had an opportunity to review this authorization and understand the intent and use; (8) the information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.

 PARENT/LEGAL GUARDIAN SIGNATURE

 RELATIONSHIP TO PATIENT

 DATE

PLEASE FILL OUT BELOW IF PAYING BY MASTERCARD, DISCOVER, AMEX, OR VISA

<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa	<input type="checkbox"/> Discover	<input type="checkbox"/> American Express
CARD NUMBER		3 OR 4 DIGIT VERIFICATION NUMBER	
SIGNATURE		EXPIRATION DATE	