Sun Pediatrics

Medical Records Release (One patient per form please)

Patient Name:_____ DOB:_____

Address:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

I hereby voluntarily authorize the disclosure/release of all medical records:

Circle One: **To** or **From**

Sun Pediatrics

Tel: 678 501 5601
Fax: 678 384 7163

Check purpose of release:

☐ Transfer to new physician

☐ Other (describe) _____

_____

Circle One: **To** or **From**

Physician, Facility or Hospital: _____

Facility Address: _____

Phone: _____

Fax: _____

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

Parent or Guardian Name (print):_____Relationship to Patient:_____

Parent or Guardian Signature:_____ Date:_____

NOTE: PLEASE PROVIDE THIS DOCUMENT TO THE FACILITY OR PHYSICIAN THAT CURRENTLY HAS YOUR RECORDS