GRAHAM PEDIATRICS OF WOODSTOCK
105 Mirramont Lake Drive, Woodstock GA 30189
Phone: 770-485-9670 Fax: 866-698-9350 www. grahampediatrics.com

Medical Records Request Form

This form authorizes us to release medical records to the person/entity you specify below.

Patient name_______________________________________ Date of Birth__________

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Patient name_______________________________________ Date of Birth__________

Patient name_______________________________________ Date of Birth__________

Fill out which ONE applies to you below (request or release)

Release Information TO:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip Code

____
Phone Number *Fax Number*

Request information FROM:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip Code

____
Phone Number *Fax Number*

Reason for the request:
__ Personal Use
__ School
__ Legal Purposes
__ Insurance purposes
__ Specialists/Referral
__ Transferring care
__ Other: ____________

Information to be released:
__ Immunization records
__ School excuses
__ All records
__ Laboratory Records

I understand that by signing below, I release Graham Pediatrics of Woodstock, LLC. and its employees, agents, officers, and affiliates from any and all liability, responsibilities, claims, and damage which may result from the release of information authorized by this Authorization to Release/Request Medical Records. My child's health care information can be disclosed as I have authorized and re-disclosed by the recipient and is no longer protected by Graham Pediatrics of Woodstock. I understand that I may revoke this authorization at any time. If not revoked earlier, this consent will remain in effect for one (1) year.

_________________________________ _________________________ __________
Parent/Legal Guardian Name & Signature Relationship to Patient Date