Medical Records Release Form

Patient Name (Last, First, MI): _____

Date of Birth: _____

Address: _____

City, State, Zip: _____Best Contact Phone: _____

Email: _____

Parent/Guardian Name: _____ Relationship: _____

My signature affirms that I am the legal guardian of the patient listed above and have full authority to request, receive, and transfer medical records. I accept responsibility for all financial obligations.

Authorize Release To:

Name (Physician/Practice): _____

Address: _____

City, State, Zip: _____

Phone:_____ Fax: _____ Email: _____

☐ Check if releasing records to Intown Pediatrics. Incoming medical records may be faxed to **404-446-4727** or **emailed** to: **medicalrecords@intownpediatrics.com.**

Information to be Released:

☐ Full Medical Record

☐ Records From/To Dates: _____

☐ Last Visit / Growth Chart / Immunizations

Reason for Release: ☐ Surgery ☐ Specialist ☐ Moving ☐ New Pediatrician/Practice

This authorization expires 90 days from: _____

☐ I authorize records to be sent via unencrypted email and accept associated risks.

Signature of Parent/Guardian: _____ Date: _____

Intown Pediatrics & Adolescent Medicine, P.C.
490 Bill Kennedy Way, SE, Atlanta, GA 30316
705 Town Blvd. NE, Ste S-560, Atlanta, GA 30319
200 East Ponce de Leon Ave, Ste 150, Decatur, GA 30030
Main: 404-446-4726 | **Fax:** 404-446-4727 | **Text:** 678-249-3394