



Medical Records Request Form

Request for Release of Medical Records from an Outside Facility

Patient Information

Patient Name(s): _____

Date of Birth: _____

Records Requested

Please send the following:

- Problem list
- Last well visit
- Growth chart
- Vaccine record
- If the patient is being seen for chronic conditions, please include only the last 2 years of records.
- If the patient has extensive medical history, please send all available records.

Releasing Facility/Previous Physician Name: _____

Phone Number: _____

Fax Number: _____

Reason for Request: _____

Please Transfer Records To:

(Indicate by circling which office records will be sent to):

Pampa Pediatrics
2155 Post Oak Tritt Rd
Suite 100
Marietta, GA 30062
Phone: (770) 973-4700
Fax: (770) 565-0326

Pampa Pediatrics
100 Stone Forest Drive
Suite 300
Woodstock, GA 30189
Phone: (770) 517-6804
Fax: (770) 517-6526

Pampa Pediatrics
11755 Pointe Place
Suite C
Roswell, GA 30076
Phone: (770) 740-0601
Fax: (770) 346-7768

Authorization

I authorize the release of the above medical records to the provider listed above. This authorization is valid for 1 year from the date of signature below.

Date Signed: _____

Parent/Legal Guardian Name (Printed): _____

Parent/Legal Guardian Signature: _____

Phone Number: _____