Northside Pediatrics
The best care for your kids

Release of Medical Records

I request that: _____
(Physician)

_____
(Practice)

_____
(Address)

_____

_____ _____
(Telephone) (Fax)

Dr. Allison B. Hill
Dr. Amy J. Hardin
Dr. Natalie M. Metzig
Dr. Tiji M. Philip
Dr. Adele H. Goodloe
Dr. Reshmi Basu
Dr. Katherine H. McGlamry
Dr. Brandon M. Estroff
Dr. Mary S. Thompson
Sara D. Dorsey, MSN, CPNP
Kathryn R. Hart, MSN, CPNP
Meredith M. Gillig, MSN, CPNP
Dr. Michael K. Levine, Emeritus
Dr. Ruth C. Brown, Emeritus
Dr. Jonathan D. Winner, Emeritus

Release the medical records and immunization dates of:

Child's Full Name: _____ DOB: _____

Child's Full Name: _____ DOB: _____

Child's Full Name: _____ DOB: _____

Child's Full Name: _____ DOB: _____

Please send the records to: Northside Pediatrics
6095 Barfield Road
Suite 200
Sandy Springs, GA 30328

I understand this consent is voluntary and that I may revoke it in writing at any time. This consent will remain in effect for no more than 90 days from the date I sign the consent. I also understand that my medical records may include information including that on mental psychiatric or psychological assessment or treatment, sexually transmitted diseases (including HIV), genetic testing, drug or alcohol treatment, or pregnancy.

I understand that the information received by Northside Pediatrics may be subject to re-disclosure by them and may no longer be protected by the federal HIPAA Privacy Rule.

_____ _____
Signature of Parent or Legal Guardian Date

_____
Relationship to patient

Sandy Springs
6095 Barfield Road
Suite 200
Sandy Springs, GA 30328
Tel: 404-256-2688
Fax: 770-685-7114

Woodstock
250 Parkbrooke Place
Suite 200
Woodstock, GA 30189
Tel: 770-928-0016
Fax: 770-685-7114

www.northsidepediatrics.com