



## Release of Medical Records

I request that: \_\_\_\_\_  
(Physician)

\_\_\_\_\_  
(Practice)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Telephone) \_\_\_\_\_  
(Fax)

Release the medical records and immunization dates of:

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: 678-324-5018