



Patient Request for Transfer of Medical Records

Name of Patient _____ DOB _____

I authorize _____ to send the
(Name of provider, practice, or institution to release information)

following information about my child to ABC Pediatrics. (Specifically describe the information to be disclosed, such as Full Medical Records, Immunization Records, Discharge Summary, Medical Summary, etc.)

(Please list description here)

Previous Provider's Phone Number _____

Previous Provider's Fax Number _____

The information will be used for the following purpose:

(May be listed as "at request of parent")

This authorization will expire on _____
(Expiration date or defined event)

Signature of Parent/Legal Guardian _____

Print Name of Parent/Legal Guardian _____

Date _____

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