KIDS FIRST
Pediatric Group, LLC

Pediatric & Adolescent Medicine

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Medical Records Releases:

I am requesting the medical records pertaining to _____
with the date of birth _____.

Records to be release by:

Physician/Facility name: _____

_____

_____

_____

Phone#: _____ Fax #: _____

I, the undersigned, hereby authorize _____ to release the following Information my child's medical records. This authorization includes release of information concerning HIV testing or treatments of AIDS, AIDS related conditions, drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions.

The following information may be released or reviewed:

_____ Discharge Summary
_____ History & Physical Examination
_____ Operative Report
_____ Emergency Department Record
____ Outpatient clinic notes
_____ Immunization (shot) records
_____ Other (specify) _____
_____

Dates of treatment _____
Or particular Illness _____

The above information is to be released to :

Kids First Pediatric Group. LLC
1045 Southcrest Drive
Suite 110
Stockbridge, Georgia 30281
Tel# 770-507-2212 Fax # 678-593-2021

The above information is requested to be released for the following purposes only.

I understand that I may revoke this authorization at any time by notifying the facility where I received medical care in writing. This authorization will cease to be effective 90 days from the date appearing below.

Date: _____ Signature: _____
(Parent and /or Authorized Person)