Request to Transfer Records from Center for Pediatric Wellness, P.C.

Please transfer the medical records for the following children

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Present Address:_____City:_____State_____Zip_____

Future Address: _____City:_____State_____Zip_____

Phone Number:_____(day)_____(evening)

I, _____ do hereby authorize Center for Pediatric Wellness PC to release:
Parent Name if <18 years-18 and older may sign for themselves

(Please check one or both)

_____All medical records pertaining to the care and treatment received at Center for Pediatric Wellness PC.

_____I do_____I do NOT authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

Reason for Records Release or Copy: ( ) Personal Copy ( )Over age 19 ( )Insurance Change ( )Moving/ Changing providers ( )Referral to Specialist ( )Unhappy with Practice (please state why)

_____

( )Other:_____

This authorization permits:
Center for Pediatric Wellness P.C. **to release records to:** _____
6000 Lake Forrest Dr. NW _____
Suite 110 _____
Atlanta, GA 30328 _____

_____**I prefer to pick-up my record rather than having them mailed. Please call when ready.**

Payment is required before records may be mailed or picked-up:

There is a $15 per patient charge with a $35 per family maximum. You may pay by check or credit card

- **If paying by check, make checks payable to Center for Pediatric Wellness, P.C.**
- **If paying by credit card we will need the following information:**

The signature below serves as authorization to transfer records:

_____**Parent if Pt is under age 18/If Pt. over age 18**