Medical Records Request

Please send records *to*: Center for Pediatric Wellness, P.C.
Elizabeth M. LeDuc, M.D.
6000 Lake Forrest Drive NW Suite 110
Atlanta, GA 30328
Office: (404) 389-1600
Fax: (404) 389-1610

Hospital/Physician Name: _____

Address: _____

Phone: _____ Fax: _____

Comments: _____

What information is being requested? (Please check the appropriate box)

☐-Entire Medical Records / Chart ☐-Lab Results ☐-Growth Charts

☐ ER or NICU Discharge Summary

☐-Other specific Medical Records:_____

☐-Newborn Discharge summary
(Please include the following): - Newborn Progress Notes
- Hyperbilirubinemia Assessment
- Hearing Screening
- Birth and Discharge Weight
- Hep. B. Vaccine
- Metabolic Screening (Form #)
- Gestational Age

(*For Northside Hospital only***): Please fax the main factsheet that has all the newborn information at time of discharge. The form is "Newborn Nursery Nursing Discharge Summary"

Mother's name _____ DOB: _____ S.S.N:_____
(Please Print)

Please transfer all the medical records of:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

The signature below serves as authorization to release the records.

Signature:_____ Date:_____