Welcome To
Kennesaw Pediatrics
Your Home for Pediatric Healthcare!

3745 Cherokee Street, Suite 401
Kennesaw, GA 30144
770 – 429-1005 – Phone
770-429-8005 Fax
www.kennesawpediatrics.com – Web
info@kennesawpediatrics.com – Email

Release Information FROM Kennesaw Pediatrics

This form authorizes us to release medical records to the person you specify below. Many parents list their child's school or childcare facility so that we may send immunization records at your request without requiring a separate form at the time of the request.

Patient's Name _____ **DOB** _____

Patient's Current Address _____

Patient's Previous Address _____

Patient's Current Phone Number _____

Information to be Released

☐ Medical Summary/Immunization Record/Growth Charts
☐ Complete Medical Records ($25.88)
☐ 3231 and /or 3300 Form
☐ School Excuse
☐ Day Care Form/ Sports Form
☐ Letter or Visit Notes

Reason for Request

☐ Personal Records ☐ Specialist/Referral ☐ School ☐ Insurance ☐ Legal
☐ Transferring Out

Transferring Reason: ☐ Relocation ☐ Insurance Change ☐ Unhappy with Staff/Practice
☐ Other: _____

Delivery of Records **please choose one**

☐ Pick-up in person ☐ Mail (only for medical records or for patients more than 50 miles from office) ☐ Fax: _____

Release Information to

(Required Information)

Name:		
Address:		
City:	State:	Zip:

By signing below, I understand that:
1. I release Kennesaw Pediatrics, P.C. and its employees, agents, officers, and affiliates from any and all liability, responsibility, claims, and damage which may result from the release of information authorized by this Authorization to Release Medical Records.
2. This consent is valid for one year from the date signed.
3. I may revoke this authorization at any time in writing, unless the action has already been taken utilizing this signed consent or if the authorization was obtained as a condition of obtaining insurance coverage.
4. The practice will not condition treatment or payment based on my signing this authorization.
5. I am signing this authorization freely; no one has pressured or coerced me to sign this authorization.
6. I acknowledge that I had an opportunity to review this authorization and understand the intent and use.
7. The information disclosed in this authorization may be subjet to re-disclosure by the practice and longer proteted by federal law.

Parent/Legal Guardian Signature _____ Relation to Patient _____ Date: _____

PLEASE FILL OUT CREDIT CARD INFORMATION BELOW *(Bubble the type of card)*			
MasterCard ☐	Visa ☐	Discover ☐	AMEX ☐
Card Number:		Security Code/CVV:	
Signature:		Expiration Date:	