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

Medical Records Release Authorization

(In to Kennesaw Pediatrics)

This release allows your previous provider to send us your child's records

Patient's Name: _____ **DOB:** _____

Patients Current Address: _____

Patient's Previous Address: _____

Patient's Current Phone Number: _____

Release Records From:
Previous Provider: _____
Address: _____
_____
Phone Number: _____
Fax Number: _____

Release Records To:
Kennesaw Pediatrics
3745 Cherokee Street NW, Ste. 401
Kennesaw, GA 30144
Phone: 770-429-1005
Fax: 770-429-8005

Description of Information to be Disclosed:

- ☐ Immunization Records, Growth Charts, Problem List
- ☐ Complete/All Records
- ☐ Other (specify): _____

Reason: To transfer or facilitate the medical care of the individual(s) listed above

Please Read and Sign

I understand the following:

1. I authorize the release of Personal Health Information (PHI) to Kennesaw Pediatrics, P.C.
2. I may revoke the authorization at any time by providing written notice to the practice.
3. I may not be able to revoke this authorization if the practice has already take action utilizing this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
4. The practice will not condition treatment or payments based on my signing of this authorization.
5. I am signing this authorization freely; no one has pressured or coerced me to sign this authorization.
6. The information disclosed in this authorization may be subject to re-disclosure by the practice and longer protected by federal law.
7. I acknowledge that I had an opportunity to review this authorization and understand the intent and use.
8. I understand that I am entitled to a copy of this authorization at the time of its execution. If so, I will make my request known.

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