Chattahoochee Pediatrics
~Caring for the Whole Child~

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MEDICAL RECORDS RELEASE

Please allow this to serve as a formal request to transfer medical records

FROM:_____

Address_____

_____

Phone_____

Fax_____

TO: **Chattahoochee Pediatrics**

3155 North Point Pkwy, Ste D200

Alpharetta, Ga 30005

Phone 770-667-6967

Fax 866-578-7440

faxes@drkute.com

NAME	**DOB**

My signature below indicates my consent to authorize any physician, nurse, other health professional or an authorized representative to release any/all medical information and /or records, which may be requested regarding physical or mental health conditions and treatment. A photocopy or facsimile of this form may be used in place of the original.

I understand that I may withdraw this authorization in writing, at any time, except to the extent that action has been taken based on this authorization. Please forward the following records to the above address or fax number. This authorization will expire one year from the date below.

- ❑ **All records**
- ❑ **Immunization record, Growth chart, Problems list, Last well check**
- ❑ **Other**_____

- ❑ **THIS IS AN URGENT REQUEST FOR VACCINATION RECORDS, THANK YOU**

_____ _____ _____

Signature of Parent/Legal Guardian **Date** **Relationship to patient(s)**

Revised 8/2019