

**Snellville Pediatrics, P.C.**  
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## MEDICAL RECORDS REQUEST

AUTHORIZATION TO REQUEST A COPY OF MY MEDICAL RECORDS TO BE FORWARDED

Please print this page, read it carefully, fill in **complete** form, and sign it. Then mail, fax, or hand-deliver it to the address in Step 2.

### Step 1—PATIENT INFORMATION:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

### Step 2—CURRENT LOCATION OF YOUR RECORDS THAT YOU WANT COPIED

Who has your records now? \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ and/or Fax \_\_\_\_\_

### Step 3—INFORMATION YOU WANT COPIED AND RELEASED

All records    or     Immunization     Labs

### Step 4—LOCATION TO SEND YOUR RECORDS TO

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ and/or Fax \_\_\_\_\_

**This authorization is valid for 90 days and may be revoked at any time in writing prior to the examination date.**

PATIENT SIGNATURE \_\_\_\_\_ date \_\_\_\_\_

**Release of Sensitive Information:** *I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric issues, sexually transmitted diseases, social services, hepatitis testing/treatment, HIV testing/treatment and/or sensitive information, I agree to its release.*

PATIENT SIGNATURE \_\_\_\_\_ date \_\_\_\_\_

**WE CANNOT SEND ANY MEDICAL RECORDS BY FAX**