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AUTHORIZATION TO RELEASE MEDICAL RECORDS

For Patients Transferring INTO Focus Pediatrics:
Patient Full Name: _____
Date of Birth: _____
Parent/Guardian Name: _____
Phone Number: _____

I hereby authorize the release of medical records FROM:

Name of Previous Provider/Practice: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Send Records TO:

Focus Pediatrics, LLC
Attn: Medical Records Department
Fax: 470-961-7300
Email: frontdesk@focuspeds.com

Records Requested (check all that apply):

- ☐ Complete Medical Records
- ☐ Immunization Records
- ☐ Growth Charts
- ☐ Developmental Assessments
- ☐ Visit/Progress Notes
- ☐ Labs and Diagnostic Reports
- ☐ Other: _____

Purpose of Request:

- ☐ Establishing Care at Focus Pediatrics
- ☐ Continuity of Care
- ☐ Other: _____

Authorization:

I understand that this authorization will remain valid for 12 months unless revoked in writing. I understand that I may revoke this authorization at any time by submitting a written request to the previous provider. I understand that once records are released, Focus Pediatrics, LLC is not responsible for how the prior provider handles that information.
Signature of Parent/Guardian/Patient (if _____ _____

Date: _____