FOCUS PEDIATRICS
WHERE THE FOCUS IS ON YOU
www.focuspeds.com

1200 Lake Hearn Dr., Suite 275
Atlanta, GA 30319
Phone: 470-993-6287
Fax: 470-961-7300
Email: info@focuspeds.com

Authorization to release medical records

Patient name: _____ Patient DOB: _____

For Patients Transferring INTO Focus Pediatrics, 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: _____ Full name: _____

Date: _____ Patient relationship: _____