



Dekalb Pediatric Center

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Phone) 404-508-1177 Fax) 404-508-9640

Date: _____

Please release any pertinent medical records and immunizations for:

Child's name _____ Date of birth _____

Also release records for the following children:

Sibling _____ Date of birth _____

Sibling _____ Date of birth _____

Sibling _____ Date of birth _____

Please check any that apply:

- _____ Personal copy
- _____ Change in insurance
- _____ Moving out of area or out of state
- _____ Changing pediatricians
- _____ Other: _____

Please check records requested:

- _____ Entire record, **excluding** records generated prior to care at Dekalb Pediatric Center
- _____ Entire record, **including** "old records" from previous doctors
- _____ Specific records only:
(Please list) _____

Please send records to: _____

Address: _____

Please fax immunization history ASAP to: _____

I understand there is a **charge** to send records to reasonably cover the administrative costs of retrieval, copying, mailing, labor and supplies. Our fees are in accordance with Georgia state law.

- **The minimum charge for a record of 2-20 pages is \$15.00. (Sibling records requested at the same time are \$10.00 each.)**
- **An additional \$0. 80 per page will be charged for each page over 20 pages.**
- **This may be paid by cash, check or charge when records are ready to be released. (Charge payments will also be accepted over the phone.)**
- **There is NO CHARGE for records to be sent to another physician we referred you to, a hospital where your child is receiving care, or records necessary to complete an application for a disability program..**

Please provide a phone number where we can reach you. If not prepaid, or there is an additional amount due, you will be called prior to records being sent. Please allow up to 5 business days to process your request. Thank you.

Parent's signature _____ Phone # _____

FOR INTERNAL PURPOSES ONLY	
# of pages _____	Cost \$ _____
Date paid: _____	Date mailed: _____