



SOUTH ATLANTA PEDIATRICS, P.A.
Pediatrics & Adolescent Medicine
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REQUEST FOR RELEASE OF MEDICAL RECORDS

PLEASE PRINT

PATIENT'S FULL NAME: _____

PATIENT'S DATE OF BIRTH: _____

I HEREBY AUTHORIZE: _____

ADDRESS: _____

PHONE & FAX NUMBER: _____

TO RELEASE RECORDS TO:

830 Eagles Landing Parkway
Suite 202
Stockbridge, GA 30281
Phone: (770) 991-2176
Fax: (770) 629-2703
Email: medicalrecords@sappamedical.com

 PARENT/GUARDIAN'S SIGNATURE

 DATE

 DAYTIME PHONE NUMBER

REASON FOR RELEASE:

- CHANGE OF INSURANCE
- MOVED
- REFERRING DOCTOR
- COURT ORDERED
- OTHER (PLEASE SPECIFY)

DATE FAXED: _____

FAXED BY: _____