SOUTH ATLANTA PEDIATRICS, P.A.
Pediatrics & Adolescent Medicine
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ASHLEY GRIFFITH, PA

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: _____