CUMBERLAND PEDIATRICS

1405 Franklin Gateway SE
Marietta GA, 30067
Office # 770.951.5400 or Fax # 770.702.5627

REQUEST FOR TRANSFER OR RELEASE OF HEALTH-RELATED INFORMATION/RECORDS

Complete this section if you want us to "***OBTAIN***" your records from another medical practice or hospital.
I hereby authorize Cumberland Pediatrics, to obtain:

All Records ☐ Certificate of Immunization ☐ Complete Vaccine Record (non-certified) ☐

Physician Notes ☐ Payment History/Account Information ☐ Other ☐

Include old records from previous primary care physician (s) ☐

From/Doctor_____ Phone/Fax_____

Address: _____ State_____ Zip Code_____

Complete this section if you want us to "***SEND***" your records to another medical practice or hospital
I hereby authorize Cumberland Pediatrics, to send:

All Records ☐ Certificate of Immunization ☐ Complete Vaccine Record (non-certified) ☐

Physician Notes ☐ Payment History/Account Information ☐ Other ☐

Include all records from previous primary care physician (s) ☐

From/Doctor_____ Phone/Fax_____

Address: _____ State_____ Zip Code_____

Time Frame from: _____ to _____ (*If applicable to request*)

For the purpose of: Transfer ☐ Personal Copy ☐ Release ☐

I understand this authorization will include release of all medical records including HIV records, Psychiatric Medical Illnesses, Drug/Alcohol abuse records, Venereal Disease and any other statutory protected diseases. **This authorization and consent will expire ninety (90) days following the date signed**. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof. I understand the potential for the disclosed information to be re-disclosed by the recipient and no longer protected.

Name of Patient: _____

Date of Birth_____ Phone: _____

Address: _____ City: _____State:_____ Zip Code: _____

_____ _____ _____
Signature of Parent/Guardian Relationship Date