

# *Pediatric Associates, P.C.*

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## CONSENT TO RELEASE MEDICAL INFORMATION

**\$35.00 transfer out fee per chart**

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

**PLEASE FORWARD THE AUTHORIZED MEDICAL RECORDS LISTED BELOW (AS INDICATED BY MY INITIALS) TO:**

- |  |   |
|--|---|
| <input type="checkbox"/> LABS                  | <input type="checkbox"/> OFFICE VISITS                  |
| <input type="checkbox"/> IMMUNIZATIONS RECORDS | <input type="checkbox"/> MENTAL HEALTH INFORMATION      |
| <input type="checkbox"/> SPECIALIST SUMMARIES  | <input type="checkbox"/> GROWTH CHARTS                  |
| <input type="checkbox"/> PREVIOUS RECORDS      | <input type="checkbox"/> HOSPITAL/ER/URGENT CARE VISITS |
| <input type="checkbox"/> ALL OF THE ABOVE      |   |

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PICKUP \_\_\_\_\_ MAIL \_\_\_\_\_

PARENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

REASON FOR TRANSFER OF RECORDS \_\_\_\_\_

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