

All About Kids Pediatrics

945 River Centre Place, Suite 200, Lawrenceville, GA 30043

Dr. Jill Overcash and Dr. Claire Wilkiemeyer

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To Obtain Records From: **All About Kids Pediatrics, 945 River Centre Place, Suite 200, Lawrenceville, GA, 30043.**

I, _____, hereby request that you release the records of:

Patient's Full Name

DOB

To: _____

_____ Phone: _____ Fax: _____

A report of the medical diagnoses, treatments and immunizations of the above named patients(s) will be provided. If other specific information is needed, please indicate below:

I understand a fee of \$15 per child up to 2 and \$35 for 3 or more children will be charged for records that I wish to pick up or have mailed directly to me. This fee is based on the Georgia Health Information Medical Association guidelines. No charge will be incurred for records that are sent directly to another physician's office or facility. These fees are due prior to medical records being copied. I also understand that I am responsible for any remaining balance on my account that has been determined to be patient responsibility.

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Current Address: _____

Home Phone Number: _____ Alternative Phone Number: _____

Amount Due: \$ _____ Payment Method: Cash Check # _____ Credit Card

Date Copied: _____ Employee's Initials: _____