Request for Medical Records

Date:_____

Child's Name/DOB: _____

Child's Name/DOB: _____

Child's Name/DOB: _____

Child's Name/DOB: _____

Your child's medical records are confidential documents. The personal and medical information they contain are guarded by privacy protections as described in the Health Insurance Portability and Accountability Act (HIPAA).

I grant permission for my child's (children's) confidential medical records - including all growth charts, immunization records, and other pertinent medical records – be released to:

The Pediatric Place, P.C.
David M. Bergman, MD, MPH, FAAP
9570 Nesbit Ferry Rd. Suite 201
Alpharetta, GA 30022
Phone: 770-640-8119

Fax: 770-988-5553

Parent/Guardian Name _____

Parent/Guardian Signature _____

Previous Medical Practice

Name _____

Address _____

_____

Ph#: _____

Fax#: _____

Updated August, 2013