Pediatric Partners
OF AUGUSTA

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Suite B
Grovetown, GA 30813

Authorization to Transfer and Release Medical Records

Patient's Name(s):

_____ **Date of Birth** _____

_____ **Date of Birth** _____

_____ **Date of Birth** _____

Patient's Physician or Provider: _____

As responsible party of this patient, I authorize Pediatric Partners of Augusta, LLC. to release the medical records of the above-named patient(s) during services rendered only from Pediatric Partners of Augusta, LLC. I authorize these medical records to be released to:

Physician or Practice: _____

Address: _____

_____

_____

Signature of Responsible Party: _____

Printed Name of Responsible Party: _____

Relationship to Patient(s): _____

Today's Date: _____

There is a $30 charge for each medical record copied or printed

Updated: June 8, 2018