Sandy Springs Pediatrics & Adolescent Medicine, PC
Fax: 404-256-1759

Dear Parent,

All medical record requests are handled by our office. We will process within 48 hours of receipt and mail to the address you indicate below.

Your child/children's records are the property of Sandy Springs Pediatrics and Adolescent Medicine. We are required by law to keep these records for 5 years after your child turns 21. Bill rates below:

Please copy –

- ☐ Immunization Records
- ☐ Last 2 years records
- ☐ Complete chart

Children Names & Date of Birth

_____

_____

_____

I understand that the records to be used or disclosed pursuant to this authorization may contain

(Initial) _____ Records relating to participation in any federally assisted drug and alcohol abuse program;

(Initial)_____ Information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes);

(Initial)_____ Information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. **By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.**

Please mail records to:

_____

_____

_____

Reason for leaving: _____

Name, address and phone number:

_____ Phone:_____

_____

_____

Parent Signature _____

Patient Signature (18 yrs & older) _____