REQUEST FOR MEDICAL RECORDS

Date: _____

I, hereby, request the release of Medical Records for the following patient(s):

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Please forward the indicated documents to:

Our Village Pediatrics, LLC

115 Academy Street, Suite 101, **Canton, GA 30114**

eFax: 470 401 1089

Requested documents for the past 12 months:

☐ Well Visit ☐ Encounters ☐ Specialist Visits ☐ Vaccination ☐ **Entire Record** ☐ Other

Parent/Guardian Name: _____

Patient Name (for 18+): _____

If you prefer that we fax to your former physician on your behalf, please provide the following:

Practice: _____

Address: _____

Phone #: _____ Fax #: _____

Signature: _____