REQUEST FOR OUTGOING MEDICAL RECORDS

DATE: ________________

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

Name:____DOB:_________________

Name:____DOB:_________________

Name:____DOB:_________________

Name:____DOB:_________________

Send Records To:

Practice Name:____

Address:____

Phone Number:__________________________Fax Number:___________________

Requested documents: Select all that apply
☐ Well Visits ☐ Encounters ☐ Specialist Visits ☐ Vaccinations ☐ Entire record ☐ Other:

____

Requested From:
Our Village Pediatrics, LLC
115 Academy Street, Suite 101, Canton GA 30114
Phone: 470-389-4970 Fax: 470-401-1089

Parent/Guardian Name: ____

Signature:____