

**PRIMECARE PEDIATRICS**

3229 Hwy 34 East, Suite 103  
Newnan, GA 30265  
(770) 251-5253  
Fax (770) 251-5254

**REQUEST FOR TRANSFER OF MEDICAL RECORDS  
TO PRIMECARE PEDIATRICS**

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I HEREBY AUTHORIZE \_\_\_\_\_ to send the  
*(Name of previous provider)*

following information about my child to **PrimeCare Pediatrics, PC.**

*Please check all that apply:*

- Full Medical Records
- Immunization Records
- Discharge Summary
- Medical Summary
- Other \_\_\_\_\_ *(Please specify)*

Name of Previous Provider's Practice/Institution: \_\_\_\_\_

Address of Previous Provider's Practice/Institution: \_\_\_\_\_

Phone Number: (    ) \_\_\_\_\_ Fax Number: (    ) \_\_\_\_\_

The information will be used for the following purposes:

\_\_\_\_\_  
**(May be listed as "at request of parent")**

This authorization will expire on \_\_\_\_\_  
**(Specify Expiration Date or Defined Event)**

**Name of Parent /Legal Guardian:** \_\_\_\_\_ **Relationship to Child/Children:** \_\_\_\_\_

**Signature of Parent /Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_