



McDonough Pediatrics, P.C.

101 Regency Park Drive, Ste 140
McDonough, GA. 30253

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Sekhar Sankaran, MD
101 Regency Park DR #140
McDonough, GA 30253

Phone: 770-957-8626 Fax: 770-957-7200

I authorize my child's Previous Doctor: _____

Street Address: _____

City, ST, ZIP: _____

To release to McDonough Pediatrics, PC the medical records for:

Patient's Name: _____ Date of Birth: _____

*******PLEASE DO NOT FAX RECORDS IF OVER 15 PAGES*******

Information to be released: ****Entire Record including Immunization Record****

By signing below, I understand that I:

- Am entitled to receive a copy of this authorization
- May inspect my records and that a fee of \$25 may be charged for duplication and print out of records
- Am authorizing the disclosure of this health information voluntarily. I can refuse to sign this authorization.
- Have the right to revoke this authorization at any time, except to the extent that action has been taken based on this authorization.
- This authorization will expire, without my express revocation, 90 days from the request date specified below.

By Signing below, you are hereby authorizing McDonough Pediatrics to request/release the requested information.

Patient/Parent/Guardian Signature

DATE

Signature of Witness

DATE