



North Atlanta  
**Pediatric**  
 associates

**The Pavilion at Lake Hearn**

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**Request to Transfer**  
**FROM**  
**North Atlanta Pediatric Associates**

**\*\*Please transfer the medical records of the following patient(s):**

Patient's Name: _____	Date of Birth: ____/____/____
Patient's Name: _____	Date of Birth: ____/____/____
Patient's Name: _____	Date of Birth: ____/____/____

**\*\*Please transfer these records to:**

Name of Physician or Practice Name: \_\_\_\_\_  
 Street Address of Office: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Is this a Permanent Transfer:** \_\_\_\_\_ Yes / \_\_\_\_\_ No

Reason for Transfer: \_\_\_\_\_

**\*\*Payment is required before charts may be mailed or picked up.**  
**There is a \$15.00 per patient charge with a \$35.00 per family maximum.**

**The signature below serves as authorization to transfer these medical records.**

**Because the patient is younger than 18 years of age, my signature serves as authorization.**

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent / Guardian Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*Patients 18 years of age or older must sign for themselves to authorize release of records.**

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_