

Elaine C. Youngblood, MD, FAAP  
Wanda J. Williams, MD, FAAP  
Sheila Blake-Clark, RN, CPNP



# KIDS FIRST

## Pediatric Group, LLC

1045 Southcrest Drive, Suite 110 | Stockbridge, GA 30281  
Telephone: (770)507-2212 | Fax: (770)507-2213  
[www.kidsfirstped.com](http://www.kidsfirstped.com)

### Authorization for Release of Medical Records

I, the undersigned, am requesting the medical records release and/or disclosure of medical information regarding:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PARENT/GUARDIAN:** Please be advised, that if this form is not filled out completely, we will not be able to receive/release your child's medical records. Please include Practice Name, Address, as well as, telephone and fax numbers. For **Newborns**, please list the hospital at which they were born.

I authorize Kids First Pediatric Group to **Release Information**  
**TO:**

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone Number      Fax Number

-OR-

I authorize Kids First Pediatric Group to **Obtain Information**  
**FROM:**

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone Number      Fax Number

\*\*\*Please indicate an expiration date for this release, by checking the appropriate box below:

Expires 6 months from the below signed date       Does Not Expire

Reason for Transfer (if applicable)

\_\_\_\_\_

Please release **ALL** pertinent medical records on the above named child. Records should include, but not limited to inpatient/hospitalization records\*, office/clinic notes, lab results and immunization (shot) records. This may also include particular illnesses and/or specific dates of treatment as specified here: \_\_\_\_\_.

\*Kids First Pediatric Group can only release information related to care received within our facility and providers.

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The signature below serves as authorization to transfer the records. I understand that these records may include psychiatric/psychological, chemical and substance abuse, HIV and AIDS information, and that I may withdraw this authorization in writing at any time, except to the extent that action has been taken based on this authorization.

\_\_\_\_\_  
**Parent/Guardian Name** *(unless 18 yrs or older)*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian Signature** *(unless 18 yrs or older)*