



TERMINATION BY PATIENT

Date

Patient Name

Chart number

This form confirms my intent to terminate my physician/patient relationship with Atlanta Pediatric Partners, PC due to _____ Atlanta Pediatric Partners, PC will no longer be responsible for my medical care after _____

I understand that upon proper authorization Atlanta Pediatric Partners, PC will be glad to provide a copy of my medical record to the physician of choice.

I understand that I may consult the county medical society or the local physician locator service to locate another physician qualified to provide my care.

I understand that Atlanta Pediatric Partners will consent to see me for emergency medical care until _____ (date stated above) and that after that date Atlanta Pediatric Partners, PC will no longer be responsible for my medical care.

Signature Date

Relationship to patient

Doctor's Signature Date

Witness Signature Date