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