# Pediatric Associates, P.C.

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## CONSENT TO RELEASE MEDICAL INFORMATION

TO: _____ PHONE: _____

_____ FAX: _____

_____

FAMILY NAME _____

Child's Name _____ DOB _____

Child's Name _____ DOB _____

Child's Name _____ DOB _____

Child's Name _____ DOB _____

REASON FOR REQUEST: _____

PLEASE RELEASE THE AUTHORIZED MEDICAL RECORDS LISTED BELOW (AS INDICATED BY MY INITIALS) TO:

[ ] LABS

[ ] OFFICE VISITS

[ ] IMMUNIZATION RECORDS

[ ] MENTAL HEALTH INFORMATION

[ ] SPECIALIST SUMMARIES

[ ] GROWTH CHARTS

[ ] PREVIOUS RECORDS

[ ] HOSPITAL/ER/URGENT CARE VISITS

[ ] ALL OF THE ABOVE

PLEASE MAIL OR FAX TO:

Pediatric Associates, P.C.
3000 JOHNSON FERRY ROAD, SUITE 204
MARIETTA, GA 30062

PARENT NAME _____ DATE _____

PARENT SIGNATURE _____

3000 Johnson Ferry Road, Suite 204, Marietta, GA 30062
(770) 993-2922 Fax (770) 552-1674