Pediatric Associates of North Atlanta, P.C.

5185 Peachtree Parkway, Ste 330
Peachtree Corners, GA 30092
770-476-9885 770-476-8482 fax

Release of Records to Our Office

To: Doctor: _____

Address: _____

_____

Phone #: _____ Fax#_____

I _____, as a parent or legal guardian of
(Please print full name)

_____, do hereby grant permission for my child's
(Child's name)
medical/immunization records to be released to the physician indicated below.

Parent/Guardian signature: _____ Date_____

Please send my child's medical/immunization records to:

[ ] Lori Desoutter [ ] Julian Gorvy [ ] Rachel Knuth [ ] Sheri Zager

Patient Identification: To be completed by parent/guardian (please print)

Name of Child: _____

Child's Date of Birth: _____

Parent/Guardian Name: _____

Reason for Transfer: _____

Parent/Guardian Address: _____

_____

Thank You