3510 Old Milton Parkway, Alpharetta, GA 30005
770.346.0132 Fax 770.346.0165
www.pediatricsgenetics.com

Authorization to Release Medical Records

I hereby request that you transfer medical records including all diagnostic procedures, lab work, immunizations, test results and treatment to Pediatric and Genetics, LLC for the following patients

Patient's legal name ________________________________ DoB _________

Patient's legal name ________________________________ DoB _________

Patient's legal name ________________________________ DoB _________

Patient's legal name ________________________________ DoB _________

Addressed to Releasing Physician ___________________________________

Practice _____________________________________

Address _____________________________________

Address _____________________________________

Telephone ___________________________________

Authorizing Signature _________________________________ Date ________

Relationship to Patient (s) (for Pediatrics) ____________________________

Address ____

Address ____