

Pediatric Associates of Johns Creek, PC

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I HEREBY CONSENT TO THE RELEASE OF THE MEDICAL RECORDS FOR THE FOLLOWING CHILD/CHILDREN.

DATE _____

CHILD'S NAME _____ DOB _____

CHILD'S NAME _____ DOB _____

CHILD'S NAME _____ DOB _____

CHILD'S NAME _____ DOB _____

PLEASE FORWARD THE INDICATED MEDICAL RECORDS LISTED BELOW TO:

**PEDIATRIC ASSOCIATES OF JOHNS CREEK, PC
4310 JOHNS CREEK PARKWAY, SUITE 150
SUWANEE, GA 30024**

- ENCOUNTER LIST/GROWTH CHART/VACCINE RECORD
- ENTIRE CHART (YOU MAY BE CHARGED A FEE BY YOUR FORMER PEDIATRICIAN)
- OTHER _____

PARENT NAME _____ PHONE NUMBER _____

PARENT SIGNATURE _____

IF YOU WOULD LIKE OUR OFFICE TO FAX THIS REQUEST TO YOUR FORMER PEDIATRICIAN, PLEASE PROVIDE THE FOLLOWING INFORMATION.

FORMER MD/PRACTICE NAME: _____

CITY, STATE: _____

PHONE: _____ FAX: _____