105 Collier Road Suite 4060 Atlanta, Georgia 30309 404.351.6662 f 404.351.6030 www.piedmontpediatrics.org

RELEASE OF MEDICAL RECORDS & PROTECTED HEALTH INFORMATION

I request that: **Piedmont Pediatrics**

Release the medical records and immunization records for:

Child's legal name: D.O.B.

Child's legal name: D.O.B.

Child's legal name: D.O.B.

Child's legal name: D.O.B.

Please send the records to:

Physician

_____

Practice

Address

_____

Telephone/ Fax

Signature: Date:

_____ Relationship to Patient(s):