PIEDMONT PEDIATRICS

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:

Physician

_____

Practice

_____

Address

_____

_____

Telephone

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:

Piedmont Pediatrics
105 Collier Rd, NW
Suite 4060
Atlanta, GA 30309
Fax: 404-351-6030

_____ Signature: Date:

_____

Relationship to Patient(s):