



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

Information regarding patient for whom authorization is made:

Patient Full Name: _____ Date of Birth: _____

Patient Full Name: _____ Date of Birth: _____

Patient Full Name: _____ Date of Birth: _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____ City: _____ State: _____ Zip _____

Phone : (____) _____ Fax: (____) _____

Please release medical records to:

Piedmont Pediatrics, LLC

105 Collier Road NW Suite 4060

Atlanta, GA 30309

Fax: (404) 793-0477

Email: medical.records@piedmontpediatrics.org

Signatures:

Parent/Legal Representative: _____ Date: _____

Relationship to Patient: _____