

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize the release of my medical records:

Childs Name:

Date of Birth:

Medical Records From: Dr. _____

Phone: _____ Fax: _____

To: ALL ABOUT KIDS PEDIATRICS

945 RIVER CENTRE PLACE, SUITE 200

LAWRENCEVILLE, GA 30043

Printed Name: _____

Address: _____

Phone: _____

Signature: _____

Date: _____