



All About Kids Pediatrics

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FORM B

MEDICAL RECORDS REQUEST FORM

PLEASE MAIL ALL MEDICAL RECORDS

I hereby authorize the release of my medical records:

Records Requested for:

Patients Full Name: _____

DOB: _____

Male ___ Female ___

Send Records To: All About Kids Pediatrics

2000 Riverside Parkway, Suite 207

Lawrenceville, Georgia 30043

From: (Name of Practice) _____

Name of Physician: _____

Address: _____

Phone: _____ Fax _____

Parents Signature: _____

Parents Printed Name: _____

Phone Number: _____

Date: _____