



All About Kids Pediatrics

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Medical Records Request Form B

I hereby authorize the release of my medical records to All About Kids Pediatrics. Please release records for:

Patient's Full Name: _____

Date of Birth: _____

Dates Requested: _____ to _____

Requesting records from

Name of Practice (Doctor): _____

Address: _____

Phone: _____

Fax: _____

Please mail all medical records to

All About Kids Pediatrics
2000 Riverside Parkway, Suite 207
Lawrenceville, GA, 30043

Parent/Legal Guardian Signature

Date

Printed Name

Phone Number