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

Revised 08/01/2019