



Roswell Pediatric Center, P.C.

Authorization for Release of Medical Records to Roswell Pediatric Center

Indicate name of physician/group that you are requesting records from:

Name of Previous Pediatrician: _____ Phone # _____

Address: _____ Fax # _____

City/State/Zip: _____

I am requesting that the medical information for my child/children to be transferred to:

3400-C Old Milton Pkwy. #545
Alpharetta, GA 30005
Phone: (770) 751-0800
Fax: (770) 751-7198

12385 Crabapple Road #100
Alpharetta, GA 30004
Phone: (770) 343-9900
Fax: (770) 343-8759

110 N. Corners Pkwy. #100
Cumming, GA 30040
Phone: (770) 888-2882
Fax: (770) 888-5562

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Signature of Parent/Guardian

Date