Authorization for Release of Medical Records
To Roswell Pediatric Center

Roswell Pediatric Center, P.C.

Name of Previous Physician/Practice:_____

Address:_____

Phone #:_____ Fax #:_____

I hereby request medical records of the patient(s) listed below to be released to:

ROSWELL PEDIATRIC CENTER, P.C.

☐ 12385 Crabapple Rd Ste 100
Alpharetta, GA 30004
Phone: (770) 343-9900
Fax: (770) 343-8759

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

☐ 110 N. Corners Pkwy Ste 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