



Roswell Pediatric Center, P.C.

Authorization for Release of Medical Records To Roswell Pediatric Center

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 200
Alpharetta, GA 30004
Phone: (770) 751-0800
Fax: (770) 343-8759

11525 Haynes Bridge Rd Ste 200
Alpharetta, GA 30009
Phone: (770) 751-0800
Fax: (770) 751-7198

110 N. Corners Pkwy Ste 100
Cumming, GA 30040
Phone: (770) 751-0800
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