



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) 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