North
Fulton
Pediatrics

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please complete this form and have it signed by the parent or guardian, it may be faxed to the physician's office that you are requesting the records from. If you do not have the information with you today for us to forward this on, please take it home with you and send it to your child's last Physician's office so that they may forward your child's medical records to us.

Previous Provider/Specialist/Facility:_____

Office Phone Number:_____

Office Fax Number:_____

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby request a summary of medical records for myself/child/children named below to include immunization records be faxed or mailed to address below:

_____Date of Birth_____

_____Date of Birth_____

BE RELEASED TO:

North Fulton Pediatrics
1285 Hembree Road, Suite 100
Roswell ,GA 30076
www.northfultonpediatrics.com
(f) 770-475-1621

Parent/Patient/Guardian signature: _____

Date: _____ **Expiration Date:** _____