

The following form may be printed. After it is completed and signed by the parent or guardian, you may fax this form to the physician's office that you are requesting the records from.

REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby request that medical records for my child(ren) named below

Be released to:

NORTH FULTON PEDIATRICS, P.C.
1285 Hembree Road, Suite 100
Roswell, GA 30076

Parent/Guardian signature _____

Date _____