Pediatric Associates Of North Atlanta
5185 Peachtree Parkway, Ste 330
Peachtree Corners, GA 30092
770-476-9885 770-476-8482 fax

To: Doctor: ____

Address: ____

____

Phone #: ____________________________ Fax #:____________________

I____, as parent or legal guardian of
(Please print full name)

____________________________________, do hereby grant permission for my child's
(Child's name)

medical/immunization records to be released to the physician indicated below.

Parent/Guardian signature: ____________________________ Date: ____________

Please send my child's medical/immunization records to:

[ ] Susan Allen **[ ] Sheri Zager**

[ ] Lori Desoutter **[ ] Julian Gorvy**

Patient identification: To be completed by parent/guardian (please print).

Name of Child: ____

Child's Date of Birth: ____

Parent/Guardian Name: ____

Reason for Transfer: ____

Parent/Guardian Address: ____

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Thank You