



Pediatric Associates of North  
Atlanta, P.C.

5185 Peachtree Parkway, Ste 330  
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### Release of Records to Our Office

To: Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_ Fax# \_\_\_\_\_

I \_\_\_\_\_, as a 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 \_\_\_\_\_

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

Julian Gorvy    Rachel Knuth    Lauren Levy    Sheri Zager    Kari Vance, N.P.

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: \_\_\_\_\_

\_\_\_\_\_  
Thank You