

RELEASE OF MEDICAL RECORDS

To: _____ Date: _____

Office ph #: _____ Office fx #: _____

Please release any pertinent medical records and immunizations for:

Patient: _____ DOB: _____

Sibling: _____ DOB: _____

Sibling: _____ DOB: _____

Sibling: _____ DOB: _____

Sibling: _____ DOB: _____

Patient(s) old address: _____

Mail Entire Record Other : _____

_____(Please fax the above specified records to: 404-508-9640)_____

Please Mail Records To:



Dekalb Pediatric Center, P.C.

350 Winn Way

Decatur, GA 30030

Ph) 404.508.1177 fx) 404.508.9640



If possible, please fax immunization records ASAP. Thank You!

Parent's Signature: _____

Date: _____