RELEASE OF MEDICAL RECORDS CONSENT FORM

Patient: ______________________________ Date of Birth: _________________________

Address: ____
City, State, Zip Code: ____

Records to be released from:

Doctor ____
Address: ____
____
Phone Number: ____

Information to be disclosed (please specify with a check mark)

________ Shot Records   _________ Entire Records
________ Selected Period of Time: _____________________________

Please release a copy of my medical records to:

Kidzcare Pediatrics, Inc.
3772 Satellite Blvd. Ste 101
Duluth, GA 30097
Tel: 770-559-4315
Fax: 770-559-4318

This authorization for release of health information will be valid for one calendar year from the date of signature. It may be revoked at any time in writing.

Parent/Guardian Signature: ______________________________ Date: __________________

Relationship to the patient: ______________________________ Date: __________________