Authorization for Release of Medical Records
To Johns Creek Pediatrics

4395 Johns Creek Parkway Suite 150
Suwanee, Georgia 30024

2000 Howard Farm Drive Suite 320
Cumming, GA 30041

770-814-1160 Fax: 770-814-1173

Name of Previous Practice: ____

Address: ____

Phone #: __________________________ Fax: __________________________________

I hereby request medical records of the patient (s) listed below to be released to:

Johns Creek Pediatrics, P.C.
4395 Johns Creek Parkway, Suite 150
Suwanee, GA 30024
(Phone) 770-814-1160
(Fax) 770-814-1173

Patient Name: ______________________________________ DOB: ___________________

Patient Name: ______________________________________ DOB: ___________________

Patient Name: ______________________________________ DOB: ___________________

Parent/Patient (18 + years old) Name: ____

Parent/Patient (18 + years old) Signature: ____

Phone number: ____