



Authorization for Release of Medical Records To Children's Care Pediatrics

John Thomas, M.D.
Jessica Norris, M.D.
Katherine Wilson, M.D.
Avery Gregory N.P

Name of previous physician/practice: _____

Address: _____

Phone: _____ Fax # _____

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

CHILDREN'S CARE PEDIATRICS, P.C.
5445 Meridian Mark Rd. Suite 380
Atlanta, GA 30342
Phone: (404) 705-3100
Fax: (404) 705-3040

Patient's name: _____ Date of Birth: _____

Patient's name: _____ Date of Birth: _____

Patient's name: _____ Date of Birth: _____

Patient's name: _____ Date of Birth: _____

Signature of Parent/Guardian

Date