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

John M. Thomas, M.D.
Jessica E. Norris, M.D.
Swetha Suresh, M.D.

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