MEADOW PEDIATRICS

RELEASE OF MEDICAL RECORDS CONSENT FORM

Records to be released from:

Name: _____

Address: _____

_____

Phone#: _____

All Records… YES_____ Selected Period of Time_____

Please release a copy of my medical records to:

Meadow Pediatrics, PLLC
10710 Medlock Bridge Rd, Ste 250
Johns Creek, GA 30097
Ph 770-870-1085
Fax 770-870-1086

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Patient's Address: _____

Guardian/Patient's Signature: _____ Date: _____

Relation to Patient: _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted illnesses, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), and/or human immunodeficiency virus (HIV).