CHILDREN'S PEDIATRIC CENTER
EAST MAIN

Michael G. Anderson, MD, FAAP
Stephanie H. Anderson, PPCNP-BC

391 East Main Street
The Historic Hawkins Building
Canton, Georgia 30114
V: 770.720.6963 / F: 770.720.6965

Authorization to Release Medical Information

PLEASE FILL IN THIS FORM AND FAX TO: 770.720.6965

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

PARENTS: Please be advised, that if this form is not filled out completely, we will not be able to receive/ release your child's medical records. Please include Practice Name, Address, Telephone, and Fax numbers. For Newborns, please list the hospital at which they were born.

I Authorize Records to be released:

To: _____ From: _____
Check correct option

To: _____ From: _____
Check correct option

Children's Pediatric Center
391 East Main Street
Canton, GA 30114
Phone: 770.720.6963
Fax: 770.720.6965

Practice: _____

Address: _____

_____

Phone: _____ Fax: _____

Reason for release of records: _____

I understand that I may revoke this authorization at any time by notifying Children's Pediatrics Center in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

_____ _____
Parent/ Guardian Signature Date

PLEASE FILL IN THIS FORM AND FAX TO: 770.720.6965