Cartersville Pediatric Associates, PC
Authorization to Release or Request Medical Information

I, ____
Print Parent/Legal Guardian Name

____
Relationship

____ ____________________
Patients Name Date of Birth

Authorize Cartersville Pediatric Associates to Release/Request the following medical information:
(circle appropriate)

() All Medical Information
() Medical History and Physical Exam
() Immunization Record
() Lab Data
() X-Ray Data
() ____________________________ please specify

This information requested in connection with:

() Further Medical Care
() Legal Proceedings
() Insurance Claims
() Compensation Claims
() ____________________________ please specify

I understand that I may revoke this consent at any time except to the extent that action has been taken based on this authorization. I also understand this authorization shall expire, without my express revocation, 90 days from the date written below.

____________________________________ ______________________________
Signature of Parent/Legal Guardian Date

Release To: ______________________________ Request Form: ______________________________
______________________________ ______________________________
______________________________ ______________________________

Phone #: ______________________________ Phone #: ______________________________

Fax #: ______________________________ Fax #: ______________________________

Office Use Only
Request mailed ( ) or faxed ( ) By ______________________ Date ______________________

Office Location:

☐ **Cartersville Pediatric Associates at Cartersville**
970 JF Harris Parkway, Suite 350 · Cartersville, Georgia 30120

☐ **Cartersville Pediatric Associates at Lake Pointe**
3950 Cobb Parkway, NW, Suite 701· Acworth, GA 30101