Cartersville Pediatric Associates, PC

Authorization to Release or Request Medical Information

I, _____

Print Parent/Legal Guardian Name

_____

Relationship

_____ _____

Patient(s) Name(s) **Date(s) of Birth**

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

( ) Last 3 years of Medical Care
( ) Immunization Record
( ) Growth Record

( ) _____ 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: Cartersville Pediatric Associates
P.O. Box 200429
Cartersville, GA 30120-9008

Phone # 770-386-3011

Fax# 770-386-9451

Request From: _____
_____
_____

Phone # _____

Fax# _____

Office Use Only

Request mailed ( ) or faxed () BY: _____ Date: _____

Office Location:

☐ **Cartersville Pediatric Associates at Cartersville**

958 A JF Harris Parkway, Suite 101 & 105
Cartersville, Georgia 30120

☐ **Cartersville Pediatric Associates at Lake Pointe**

3950 Cobb Parkway, NW, Suite 701
Acworth, Georgia 30101