Sandy Springs
8601 Dunwoody Pl, Suite 565
Sandy Springs, GA 30350
Phone: 470-500-6844
Fax: 833-992-2227

Authorization for Release of Medical Records

To: Doctor or Practice Name: ____

Street Address____

City_______________________________________**State:**___________**Zip Code:**___________________

Fax Number:______________________________**Phone:**______________________________________

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Please send copies of my child's/children's complete medical records to the following address:

Flourish Pediatrics
8601 Dunwoody Pl, Suite 565
Sandy Springs, GA 30350
Phone: 470-500-6844
Fax: 833-992-2227

Child's Name:____**DOB**__________________________

Child's Name:____**DOB**__________________________

Child's Name:____**DOB**__________________________

Address:____

Parent Name:____**Phone Number:**_____________________

Signature of Parent or Guardian____

Relationship to the Patient____

Date________________