Tiftarea Pediatrics

Records Release:

Authorization to Send Medical Records to Tiftarea Pediatrics:

I, ______________________________________, Parent/Guardian of ___________________________________,
(Parent/Guardian Name) (Patient Name)

Date of Birth: ____________________________, SSN: ____

Authorize: ____
(Name of Person/Organization/Office Releasing Information)

____
(Full Address)

____
(Phone) (Fax)

To release the standard set of medical records (Immunization record, growth charts, problem list, most recent well visit, physical exams, all consultant notes, and other information important to the patient's ongoing care) to:

Tiftarea Pediatrics
215 West 12th Street
Tifton, GA 31794
P: (229) 396-5335
F: (229) 396-5330
www.tiftareapediatrics.com

____ ___________________
(Parent/Guardian Signature) (Date)

____ ___________________
(Witness Signature) (Date)

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