

Atlanta Children's ENT, P.C.
3400-C Old Milton Parkway, Suite 465
Alpharetta, Georgia 30005
(770) 777-1100 Fax (770) 751-9089

Please fill out form completely

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
Please fax records to (770) 751-9089

Patient Name: _____

Patient Date of Birth: _____ Gender: M / F

I Request and Authorize: _____
Please enter Primary Care Doctor's Name

To Release medical information to: **Atlanta Children's ENT**

Medical Information (For Office Use Only):

Problem List: _____ Other: _____

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically one (1) year from the date indicated below.

Signature of Parent or Legal Guardian

Date

Relationship to patient

For office use only: (Please Stamp)