

11050 Crabapple Road  
Suite 120  
Roswell, GA 30075  
(770) 518-9277  
(770) 518-8718 fax

1111 Alderman Drive  
Suite 250  
Alpharetta, GA 30005  
(678) 527-1555  
(678) 527-1559 fax



**Pediatric  
Physicians,  
PC**

Roy Benaroch, MD, FAAP  
Jean A. Muench, MD, FAAP  
Jennie Gropper Biggs, MD, FAAP  
Michelle Kelly, MD, FAAP  
Jina Brown, MD, FAAP  
Elizabeth R. Bien, MD, FAAP  
Stanton Stebbins, MD  
Lara Burer, CPNP

*Founded by Dr. Patty, 1992*

**REQUEST FOR MEDICAL RECORDS FROM ANOTHER OFFICE  
WITH PATIENT AUTHORIZATION**

**Records requested from:**

Name and Address of Doctor, Hospital or Medical Facility

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**Release information to:**

Please release medical record information to Pediatric Physicians:

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Roswell, GA 30075  
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Please fax immunization records and mail the remaining records. Thank you.

Specific record request: \_\_\_\_\_  
\_\_\_\_\_

**Request is for:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Add'l Names: \_\_\_\_\_ DOB: \_\_\_\_\_  
Add'l Names: \_\_\_\_\_ DOB: \_\_\_\_\_  
Add'l Names: \_\_\_\_\_ DOB: \_\_\_\_\_

\*\*\*\*\*

My signature below serves as an authorization to release the above information to the named party. I understand that these records may include psychiatric, chemical and substance abuse, HIV, and AIDS information and that I may withdraw in writing this authorization at any time, except to the extent that action has been taken based on this authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(expires 90 days from date signed)

Name (please print) \_\_\_\_\_

Relationship to patient: Parent \_\_\_\_\_ Self (18+) \_\_\_\_\_ Other Guardian \_\_\_\_\_

If Other Guardian, please specify relationship \_\_\_\_\_

Date Signed: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**www.PediatricPhysiciansPC.com**

Happy

Healthy

Safe