AUTHORIZATION TO RELEASE INFORMATION

Identification of Parent/Guardian/Custodian is required

Please print clearly

Parent/Guardian/Custodian ______________________________ Relationship __________

Address ____ Telephone#______________

City/State/Zip ____

Do you have **LEGAL CUSTODY of the child/children?** Yes No

Patient ____ Date of Birth ___/___/___

Patient ____ Date of Birth ___/___/___

Patient ____ Date of Birth ___/___/___

Patient ____ Date of Birth ___/___/___

I authorize the release of medical information from the medical records (s) of the above patients.

From: Doctor/Healthcare Facility/Other: ______________________________________

Address: ____

City/State/Zip: ____

Phone# ____________________________ Fax: ____________________

To: Ringgold Pediatrics

7494 Battlefield Pkwy

Ringgold, Ga 30736

706-935-5437 Fax# 706-395-3004

I am switching my child to Ringgold Pediatrics for the following reason(s)

____

____

Signed: ________________________________ Date: ________________________

Relationship: ____

** Please **MAIL** If More Than 50 Pages**