Pediatric Partners
OF AUGUSTA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO PEDIATRIC PARTNERS OF AUGUSTA, LLC

Requesting medical records from:

Provider _____

Address _____

_____

Phone _____ Fax_____

Patient Name _____ DOB_____

_____ DOB_____

Patient Address _____

_____

I authorize you to furnish Pediatric Partners of Augusta, LLC my child(ren)'s medical records.

Signature of Responsible Party _____

Relationship to Patient _____

Date _____

(706) 854 – 2500

Please send records to:

_____1303 d'Antignac Street, Suite 2600, Augusta GA 30901 Fax (706) 774-7209

_____P.O. Box 1758, Evans Ga 30809 Fax (706) 854 - 2534