



Authorization for Release of Medical Records

Requested records are being released from:

Flourish Pediatrics
8601 Dunwoody Pl, Suite 565
Sandy Springs, GA 30350
Phone: 470-500-6844
Fax: 833-992-2227

Please send copies of my child's/children's complete medical records to the following address:

To: Doctor or Practice Name: _____

Street Address _____

City _____ State: _____ Zip Code: _____

Fax Number: _____ Phone: _____

Child's Name: _____ DOB _____

Child's Name: _____ DOB _____

Child's Name: _____ DOB _____

Address: _____

Parent Name: _____ Phone Number: _____

Signature of Parent or Guardian _____

Relationship to the Patient _____ Date _____