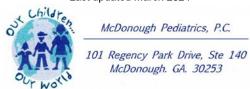
Last updated March 2024



AUTHORIZATION TO OBTAIN MEDICAL INFORMATION A W8 cbci [\'DYX]Uff]Wg

101 Regency Park DR #140 McDonough, GA 30253

Phone: 770-957-8626 Fax: 770-957-7200

I authorize my child's Previous Doctor: Street Address: City, ST, ZIP:			
		To release to McDonough Pediatrics	, PC the medical records for:
		Patient's Name:	Date of Birth:
*****PLEASE DO NOT FAX RECORDS IF OVER 15 PAGES*****			
 Am authorizing the disclosure o Have the right to revoke this au on this authorization. 	•		
By Signing below, you are hereby author	rizing McDonough Pediatrics to request/release the requested information.		
Patient/Parent/Guardian Signature	DATE		
Signature of Witness	DATE		

Office: 770-957-8626 | Fax: 770-957-7200