Princeton Lakes Pediatrics

Authorization to Release Medical Information

Date	
Patient Name	Patient Date of Birth (Month,Day,Year)
Patient Address	
Patient City, State, Zip	

I hereby authorize these records to be released immediately from:

Practice Name

Physician Name

Address

Phone Number

Fax Number

I authorize these records to be released to:
Princeton Lakes Pediatrics
3885 Princeton Lakes Way, Suite 302
Atlanta, GA 30331
Phone (404) 629-1880
Fax (404) 629-1935

Signature of Parent (Guardian)	Date
Print Name of Parent (Guardian)	
Signature of Witness	Date
Print Name of Witness	