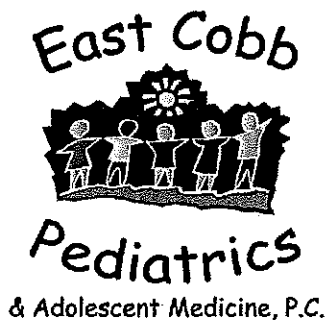


**Marietta**  
1121 Johnson Ferry Road, Suite 220  
Marietta, GA 30068  
Ph: 770-977-0094  
Fax: 770-509-9463



**Kennesaw**  
6110 Pine Mountain Road, Suite 202  
Kennesaw, GA 30152  
Ph: 770-795-4553  
Fax: 770-795-4513

## Request for Release of Records

To: Doctor or Practice Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**East Cobb Pediatrics and Adolescent Medicine**  
1121 Johnson Ferry Road, Suite 220  
Marietta, GA 30068  
Phone: 770-977-0094  
Fax: 770-509-9463

Child's Name: \_\_\_\_\_ DOB \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_

Parent Name \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

This authorization is valid one year from date signed.