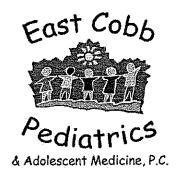
Marietta

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

To: Doctor or Practice Name:_

This authorization is valid one year from date signed.

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

City:	State:	Zip Code:
Fax Number:	Phone:	
Please send copies of my chilo address:	d's/children's complete me	edical records to the following
	Cobb Pediatrics and Adolesce 121 Johnson Ferry Road, Su Marietta, GA 30068 Phone: 770-977-0094 Fax: 770-509-9463	ite 220
Child's Name:		DOB
Child's Name:		DOB
Child's Name:	and the second s	DOB
Address:		
Parent Name	Pho	one Number:
Signature of Parent or Guardian:		
Date:		