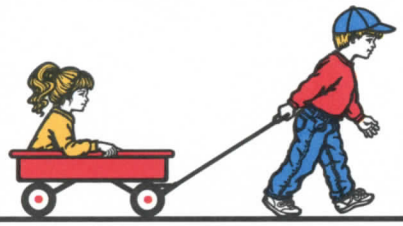

Pediatric Associates of Johns Creek, P.C.

ROBERT M. LICATA, M.D., F.A.A.P. KAREN M. CARROLL, M.D., F.A.A.P. PENNY M. FORMAN, M.D., F.A.A.P.
KARA L. BARLOW, M.D., F.A.A.P. AARON M. WORTH, M.D., F.A.A.P.

CONSENT TO RELEASE MEDICAL RECORDS TO PAJC

I DO HERBY AUTHORIZE THE RELEASE OF RECORDS FOR THE FOLLOWING PATIENTS:

Patient Name: _____ DOB: ____/____/_____

Patient Name: _____ DOB: ____/____/_____

Patient Name: _____ DOB: ____/____/_____

Patient Name: _____ DOB: ____/____/_____

PREVIOUS DOCTOR'S INFORMATION:

NAME OF PRACTICE: _____

PHONE: _____ **FAX:** _____

AT THIS TIME, I WOULD LIKE TO REQUEST THE FOLLOWING :

- BASICS [immunization record, growth chart, summary of encounters, & copy of last check-up]
- ENTIRE CHART [previous MD may have a copying fee]
- OTHER _____

REASON FOR REQUESTING RECORDS:

- RECORDS FROM ER/URGENT CARE VISIT FOR CONTINUATION OF CARE: Date(s) of Service _____
- RECORDS FROM SPECIALIST FOR CONTINUATION OF CARE: Date(s) of Service _____
- TRANSFERRING FROM PRACTICE
  - Moved
  - New Pediatrician
  - Other _____

PLEASE FORWARD THE INDICATED MEDICAL RECORDS TO:

- MAILED: Address: **PEDIATRIC ASSOCIATES OF JOHNS CREEK**
  4310 JOHNS CREEK PARKWAY, SUITE 150
  SUWANEE, GEORGIA 30024
- FAXED: Fax #: **770-476-1674**
  Phone #: **770-476-4020**

PRINT PARENT/PATIENT (18+YEARS OLD) NAME: _____ DATE: ____/____/_____

PARENT/PATIENT (18+YEARS OLD) **SIGNATURE:** _____

PHONE NUMBER: