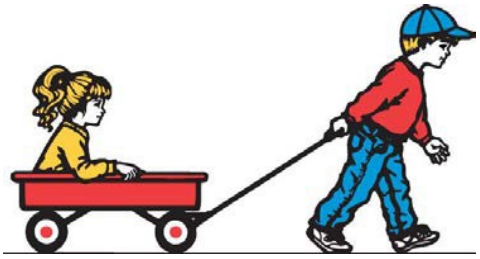

Pediatric Associates, PC

ROBERT M. LICATA, M.D., F.A.A.P. MARYGRACE ANI, M.D., F.A.A.P. GAIL PIKHOLZ, M.D., F.A.A.P.

I HEREBY CONSENT TO THE RELEASE OF THE MEDICAL RECORDS FOR THE FOLLOWING PATIENT

DATE_____

PATIENT NAME_____**DOB**_____

PATIENT NAME_____**DOB**_____

PATIENT NAME_____**DOB**_____

PATIENT NAME_____**DOB**_____

PLEASE FORWARD THE INDICATED MEDICAL RECORDS LISTED BELOW TO:

PEDIATRIC ASSOCIATES, PC
2863 JOHNSON FERRY RD • SUITE 100
MARIETTA, GA 30062

- □ **ENCOUNTER LIST/GROWTH CHART/VACCINE RECORD**
- □ **ENTIRE CHART** (YOU MAY BE CHARGED A FEE BY YOUR FORMER PEDIATRICIAN)
- □ **OTHER** _____

PARENT/PATIENT (18+ YEARS OLD) **NAME**_____

PHONE NUMBER: _____

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

IF YOU WOULD LIKE OUR OFFICE TO FAX THIS REQUEST TO YOUR FORMER PEDIATRICIAN, PLEASE PROVIDE THE FOLLOWING INFORMATION.

FORMER MD/PRACTICE NAME: _____
CITY, STATE: _____
PHONE:_____**FAX:** _____