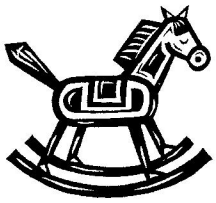

POTTS PEDIATRICS & ADOLESCENT MEDICINE
P: 770-461-5003
F: 770-461-4939
356 N. Jeff Davis Drive
Fayetteville, GA 30214

Request for Release of Medical Records

I authorize _____

_____

to release medical records to **POTTS PEDIATRICS & ADOLESCENT MEDICINE & PREVENTATIVE CARE, LLC**

_____.

Patient(s) Name (DOB): _____

_____

_____

_____

Parent(s)/Guardian(s) Name: _____

_____

I Hereby Request the Following Records:

Record of Immunization _____

Summary of Medical Records _____

Copy of Complete Medical Records _____

Copy of Medical Records Pertaining to: _____

_____

Signature: _____

Date of Request: _____