



"Come grow with us"

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**CONSENT TO RELEASE INFORMATION**

Please transfer the medical records of:

Patient Name

Date of Birth

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Home Phone Number \_\_\_\_\_

**Release Information From:**

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

**Release Information To:**

North Point Pediatrics

11975 Morris Rd. #210

Alpharetta, GA 30005

Phone: 770-664-0088

Fax: 678-336-1411

The signature below serves as authorization to transfer the records. I understand that these records may include psychiatric, chemical and substance abuse, HIV, and AIDS information, and that I may withdraw this authorization in writing, at any time, except to the extent that action has been taken based on this authorization.

\_\_\_\_ If patient is 18yrs old, they may sign, otherwise parent's signature serves as authorization. The patient is \_\_\_\_ my child(ren) \_\_\_\_ Other \_\_\_\_

Authorized Signature

Date

Print Name

11975 Morris Rd., Suite 210 • Alpharetta, GA 30005

Telephone: (770) 664-0088 •

www.northpointpediatrics.biz