"Come grow with us"

Greg R. Cabrera, M.D., F.A.A.P. - Stephanie Muller-Dale, M.D., F.A.A.P.

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Transfer the medical records of: Date of Birth

______________________________ __________
______________________________ __________
______________________________ __________
______________________________ __________

Home Address:
____
____
____

Primary Contact Number: ______________

****Please only send most recent Well Child Check, Immunizations, and Growth Charts****

Release Information From:

Name: ______________________

Address: ______________________

____

Phone: ______________________
Fax: ______________________

Release Information to:
North Point Pediatrics
3180 North Point Parkway Ste 410
Alpharetta, Ga 30005
Phone: 770-664-0088
Fax: 678-336-1411

******* MAIL RECORDS IF MORE THAN 50 PAGES*************

The signature below serves as authorization to transfer the records. I understand that these records may include psychiatric, chemical and substance abuse, HIV/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 18 years old, they may sign, otherwise the parent/ legal guardian's signature serves as authorization.
The patient is _____ my child(ren) ____ Other.

______________________________ ______________
Authorized Signature Date

____
Print Name