



Medical Records Release Form

I, _____, as parent or legal guardian of _____, do hereby grant

permission for my child's medical & immunization records to be released to the physician indicated below. I understand there may be a charge for copying full medical records.

Please send my child's medical records to:

Northside Pediatrics, PC
145 North Crest Blvd
Macon, Ga 31210
Phone 478-477-4044
Fax 478-477-7076

PatientName: _____ DOB: _____

Parent or Guardian's Name _____

Address: _____

Signature: _____ Date: _____