DACULA PEDIATRICS

Dr. Sarvpreet Kaur. MD, FAAP.

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

Previous Provider/Specialist/Facility: _____

Office Phone Number: _____

Office Fax Number: _____

I hereby authorize the release of the following documents for the children named below:

_____ Date of Birth_____

_____ Date of Birth_____

- ❖ Vaccination Record

BE RELEASED TO:

Dacula Pediatrics
3625 Braselton Highway, Suite 202,
Dacula, Georgia 30019
Fax: 470-238-3222 Ph: 470-655-7166

Parent/Guardian signature:_____

Date: _____

Other Notes as specified: