



300 Dawson Commons Circle, Suite 320 · Dawsonville, GA 30534  
Tel: (706) 216-2771 · Fax: (706) 216-2944

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**AUTHORIZATION TO RELEASE MEDICAL RECORDS:**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Release Medical Records From:**

Previous Pediatrician / Doctor's Name / Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I am requesting the medical records for my child/children be transferred to:

**DAWSON PEDIATRICS, PC  
ATTN: MEDICAL RECORDS  
300 DAWSON COMMONS CIRCLE, SUITE 320  
DAWSONVILLE, GA 30534  
(706) 216-2771 FAX (706) 216-2944**

**SIGNATURE:** \_\_\_\_\_

Parent / Legal Guardian

**PRINTED NAME:** \_\_\_\_\_

Parent / Legal Guardian

**DATE:** \_\_\_\_\_