Nuestros Niños
Our Kids Pediatrics

~ Authorization to Release / Receive Medical Records ~

Date: _____ / _____ / _____

Release ☐ Requesting ☐

Medical Facility: _____

Address: _____

Phone # ( ) _____ Fax # ( ) _____

Patient's Name:_____ DOB: _____ / _____ / _____

I (Print Name) _____ authorize Nuestros Niňos Our Kids Pediatrics (Parent/Guardian if not patient) to release/receive my medical records (including medical information related to the diagnosis or treatment of HIV testing, Drug & Alcohol or a Psychiatric condition as indicated) as specified.

Parent Signature: _____ Date:_____

_____ Lab & X-Ray Results _____ Immunization Records _____ Medical Records

Please mail the photocopies or fax to the following:

NUESTROS NIŇOS OUR KIDS PEDIATRICS

777 Franklin Gateway, Marietta, GA 30067

Phone # (770) 732-6007 Fax# (770) 732-8242