Stockbridge Pediatrics, P.C.

Marixie Gilrane, M.D.
239 Village Parkway Center. Suite 110
Stockbridge, GA 30281

REQUEST FOR MEDICAL RECORDS RELEASE

Physician's Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Dear Dr: _____:

The following individual has asked us to request that his or her child relevant medical records, i.e. office notes, hospital reports, lab results be released and forwarded to our office:

Patient Name: _____

Birthdate: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file.

Thank you for expediting this request. Please send these records to our office address show above.

I hereby authorize the release of all necessary medical records to Stockbridge Pediatrics, P.C.

I wish for them to be forwarded as soon as possible. This release expires 120 days after execution date.

Patient's Signature: _____ Date: _____
(or parent if patient is a minor)

Patient's Street Address: _____

City: _____ State: ____ ZIP Code: _____

Signature of Witness: _____