Peach Clinic

3030 Old Atlanta Rd, Suite 500 Cumming GA 30041
Phone (770) 203-2000
Fax (770) 886-7903

Medical Record Release Request

To:

Physician _____

Address _____

_____

Phone _____

Fax _____

Dear Doctor,

I hereby authorize and request you to release my child's complete medical records in your possession to:

Peach Clinic
3030 Old Atlanta Rd Ste 500
Cumming GA 30042
Phone: (770) 203-2000
Fax : (770) 886-7903

Patient Name: _____

Date of Birth: _____

Signature _____ Date _____