Peach Clinic

Medical Record Release Request

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

☐ **Bethelview Office**
2320 Atlanta Hwy, Ste 105
Cumming GA 30040
Phone (770) 203-1000
Fax (770) 886-9908

Physician/ Practice _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____

I hereby authorize you to release the following medical records of ☐ myself / ☐ my child in your possession to Peach Clinic. Please include the following components of my medical records.

Name: _____ **DOB** : _____

☐ Recent 3 Office Notes
☐ Recent 3 Lab Results
☐ Last Wellness (Physical) Exam Notes
☐ Immunization Record
☐ Discharge Summary
☐ Major Diagnostic Procedures
☐ ER Medical Record
☐ All records
☐ Other: _____

Signature: _____ **Date** _____

Print Name: _____ ☐ Parent