all worlds
HEALTH & PEDIATRICS

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REQUEST FOR MEDICAL RECORDS/INFORMATION

Dear: _____
(physician or other health practitioner)

Address: _____

Phone: _____ Fax: _____

PLEASE RELEASE MEDICAL RECORDS/INFORMATION FOR THE FOLLOWING PATIENT

Patient: _____ DOB: _____

Street Address: _____

City/Town: _____ State: _____ Zip: _____ Phone: _____

I AUTHORIZE THE RELEASE OF THE FOLLOWING MEDICAL INFORMATION FOR THE PATIENT NAMED ABOVE:

☑ Permission to exchange medical information regarding patient
☐ Labs
☐ Summary
☐ Growth Chart
☐ Last Well Visit
☐ Vaccine Records
☐ Other (Please describe): _____
_____
_____

PLEASE SEND RECORDS TO:

Arlene Dijamco, MD, FAAP
All Worlds Pediatrics, PC
800 Old Roswell Lakes Pkwy, Suite 300
Roswell, GA 30076
FAX: 855-756-8564 Phone: 678-629-3988

THE SIGNATURE BELOW SERVES AS AUTHORIZATION TO RELEASE RECORDS

AUTHORIZED SIGNATURE: _____
(Parent/ Guardian if patient is < 18), OR (Individual if patient is 18 or older)

PRINTED NAME: _____ DATE: _____