

LAWRENCEVILLE PEDIATRICS, P.C
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VICKI MORGAN, M.D.
LORI ROBERTS, CPNP
MELISSA MAGILL, M.D.

AUTHORIZATION TO RELEASE RECORDS

TO: _____

By signing this authorization, I am authorizing you to disclose the following information about my child/children.

Please release this information to: Dr. Vicki Morgan M.D.
3815 Harrison Road
Loganville G.A. 30052

This authorization expires on _____.

Patient's Name _____ Date of Birth _____

Patient's Name _____ Date of Birth _____

Patient's Name _____ Date of Birth _____

Parent's Name _____ Signature _____

Date: _____ Address _____
