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AUTHORIZATION TO RELEASE RECORDS

To: _____

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

Please release this information to: Dr. _____,
Lawrenceville Pediatrics, PC
980 Lawrenceville Highway
Lawrenceville, Georgia 30045

This authorization permits you to disclose the following information about my child/children: (CIRCLE) immunization records, growth charts, laboratory results, consultation records, complete medical records, and/or

This information will be used for the following purpose: _____

This authorization expires on _____.

Patient's Name _____ Patient's Name _____

Birthdate _____ Birthdate _____

Parent's Name _____ Parent's Signature _____

Date _____ Address: _____
