Authorization for release of medical records to Omega Pediatrics
FAX: 888-723-2802 TEL: 470 485 6342

Previous Office:_____

Address:_____

City/State/Zip:_____

Phone/Fax:_____

I authorize the transfer of the entire medical records including patient visits growth charts, vaccine records, laboratory results and mental health referrals of the below listed children to

Omega Pediatrics
1305 Hembree Road, Suite 203
Roswell, GA 30076
Telephone: 470-485-6342
Fax: 888-723-2802

Child's Name_____Date of Birth:_____

Child's Name_____Date of Birth:_____

Child's Name_____Date of Birth:_____

Child's Name_____Date of Birth:_____

Parent/Guardian's name:_____

Cell Phone:_____

Parent/Guardian's Signature:_____Date_____