RECORDS RELEASE

TO:____

PHONE:____ FAX:_______________________

I hereby authorize you to release records to:

<u>**Bright Pediatrics P.C.**</u>

1507 Professional Court	4700 Battlefield Pkwy #210
Dalton, Georgia 30720	Ringgold, GA 30736
(706) 529-4600 office	(706) 841-0150 office
(706) 529-4633 fax	(706) 841-0151 fax

The complete history in your possession including ALL correspondences and data concerning Illness and/or treatment.

Patient's Name:____

Date of Birth:____

Address:____

Signature:____

Relationship to Patient:____