SHAH PEDIATRICS, INC.

Medical Release Form

310 Philip Blvd.
Lawrenceveille, GA 30045
Phone: 770-962-3141

Taru N. Shah, M.D., F.A.A.P. May Hawawini, M.D., F.A.A.P.

To Physician: _____

Address: _____

_____

To Public Health Clinic: _____

Address: _____

_____

I, _____, as parent or legal guardian of
(please print full name)

_____, do hereby grant permission for my child's
(child's name)

medical/immunization records to be released to the physician indicated below.

Parent/Guradian signature: _____ Date: _____

Please send my child's medical/immunization records to:

Physician: **SHAH PEDIATRICS, INC.**
310 Philip Boulevard
Lawrenceville, Ga. 30045
Phone: 770-962-3141
Fax: 770-962-3155

Patient Identification: To be completed by parent/guardian, please print

Name of Child: _____

Child's Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Address: _____

_____

_____

Thank You, Taru Shah, M.D.