Dr./Practice: _____
Address: _____
_____
Phone number: _____
Fax number: _____

Please allow this to serve as a formal request to transfer the medical records
For the following patients to:

Vaishali B. Kute, MD FAAP IBCLC
Priya Thomas, MD FAAP
3155 North Point Pkwy, Ste D200
Alpharetta, GA 30005
Phone 770-667-6967 Fax 866-578-7440

Name	DOB

My signature below indicates my consent to authorize any physician, nurse, other health professional or an authorized representative to release any/all medical information and /or records, which may be requested regarding physical or mental health conditions and treatment. A photocopy or facsimile of this form may be used in place of the original.
I understand that I may withdraw this authorization in writing, at any time, except to the extent that action has been taken based on this authorization. Please forward the following records to the above address or fax number. This authorization will expire one year from the date below.

- ❑ Immunization record
- ❑ Growth chart, problem list, last well check
- ❑ All records

_____ _____ _____
Parent/Guardian Signature Date Relationship to patient(s)