THE WORLD OF PEDIATRICS

Dr. Lyudmila Vayman
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Tel: 770-442-5437 Fax: 770-674-3777

Date: _____

Description of Health Information to Be Released:

_____

_____

_____

For the following patient(s):

1) Patient's Name: _____
Patient's DOB: _____

2) Patient's Name: _____
Patient's DOB: _____

3) Patient's Name: _____
Patient's DOB: _____

4) Patient's Name: _____
Patient's DOB: _____

5) Patient's Name: _____
Patient's DOB: _____

Please send the records to the following fax or address:

Physician/ Practice Name: _____
Street Address: _____
City, State, Zip Code: _____
Telephone Number: _____
Fax Number: _____

If you have any questions, please, contact me at _____.

Thank you,

_____ _____ _____
Parent/Guardian printed name Parent/Guardian signature Date