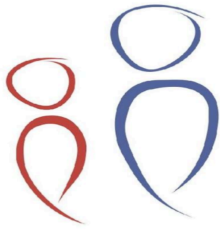

Sandy Springs Pediatrics and Adolescent Medicine, PC

☐Estonna Wells-Jarrett, MD ☐Vanna Jackson, MD ☐ Sarah Aldridge, MD

☐ Sarah Robertson, MD ☐ Megan Fellows, MD

To: Doctor/Clinic: ____Fax: _____________________

Address: ____ Phone: __________________

I ____________________________, as parent or legal guardian of the child/children below, do hereby grant

permission for ☐Immunizations ☐ Growth Chart ☐Last PE ☐ Problem List ☐ Last ADD/ADHD visit note

☐other____

to be sent to above physician at Sandy Springs Pediatrics.

☐ **Patient is in office now, please fax as soon as possible.**

☐ Child's appointment is on ____________________________. Please mail or fax in time for

Child's full name __________________________________ DOB: _____________

Child's full name __________________________________ DOB: _____________

Child's full name __________________________________ DOB: _____________

Child's full name __________________________________ DOB: _____________

Child's full name __________________________________ DOB: _____________

Please contact me if there are any charges associated with this request at ______________________.

Parent/Guardian signature ____________________________ Date: _____________

PLEASE SEND MY CHILD/CHILDREN'S MEDICAL/IMMUNIZATION RECORDS TO:

Sandy Springs Pediatrics & Adolescent Medicine, PC
6100 Lake Forrest Dr. Ste 100
Sandy Springs, GA 30328
Phone: 404-252-4611 Fax: 404-256-1759