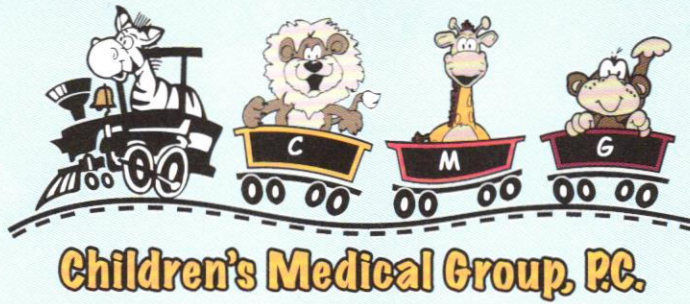


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 Julie P. Berry, C.F.N.P.

FAX TRANSMITTAL-MEDICAL RECORDS REQUEST

Date: _____
 Fax To: _____
 From: _____

Please provide requested records on the following children:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

- Immunization records
- Laboratory data, dated _____
- Any other pertinent facts we should know

Parent Name: _____

Parent's Signature _____

- Patient in the office now
- Please fax to: _____
- Please have records ready for pick up on _____
- Please mail complete records to: _____

**Please call the office (circled below) if you have any questions or received this fax in error.
 Thank you.**

Century Center Office
 1875 Century Blvd. N.E., Suite 150
 Atlanta, Georgia 30345
P: 404-633-4595 F: 404-633-6637

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 125 Clairmont Ave., Suite 190
 Decatur, Georgia 30030
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