Release Of Patient Information

2001 Peachtree Road NE
Suite 670,
Atlanta, GA 30309
Ph: (404) 963-1544
Fax: (404 963-1697

Patient making request:

Name:
Date of Birth:

Medical Records are being requested from:

Physician:
Office Phone:
Office Fax:

Patient Signature:_____

Please fax patients medical records to the above listed fax number. Thank you.