Atlanta Arthritis Center, P.C.
11660 Alpharetta Hwy Ste 265
Roswell, GA 30076
Phone: 678-867-0000 Fax: 678-867-0003

REQUEST FOR RECORDS RELEASE

Physician's Name: ____

Street Address: ____

City: ______________________ State: __________ ZIP Code: _____

Dear Doctor: ____________________:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name: ______________________________ DOB: __________

Patient's Address: ________________ City: ________ State: ___ ZIP Code: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please be sure to include x-ray reports(including bone density reports) and lab results.

Thank you for expediting this request. Please send these records to our office address show above. If the requested records are less than 25 pages please fax to our office. If requested records are over 25 pages please mail to above address.

I hereby authorize the release of all necessary medical records to ________________. I wish for them to be forwarded as soon as possible.

Patient's Signature: ______________________________ Date: ____________
(or parent if patient is a minor)

Signature of Witness: ____

©2000 Professional Management & Marketing