North Atlanta Surgical Associates

5115 New Peachtree Road
Suite 202
Chamblee, GA 30341
Phone 678-336-5951 Fax 678-336-5955

Date: ____________________

Name of Physician/Medical Facility ____________________

Address ____________________

City, State, Zip Code ____________________

Fax Number ____________________

I hereby request that a copy of my medical records be released to:

____

Please choose _____ mail _____ Fax my records to the address/fax number shown above.

Thank you for your assistance.

____
Patient Signature

____
Printed Name

____________________ ____________________
Date of Birth Social Security Number

____
Other names under which my account might be located?

If you have trouble locating my records, I may be reached:

____
Home Address

____
City, State, and Zip Code

____________________ ____________________
Home Phone Cell Phone