North Atlanta Surgical Associates

980 Johnson Ferry Road NE.

Suite. 880

Atlanta, GA 30342

Phone: 404-255-8304 Fax: 404-256-4578

Date: _____

Name of Physician/Medical Facility: _____

Address: _____

City, State, Zip Code: _____

Fax Number: _____

I hereby request that a copy of my medical records be release 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 Phone Cell Phone