Old Atlanta Office
3030 Old Atlanta Rd, Suite 500
Cumming GA 30041
Phone (770) 203-2000
Fax (770) 886-7903

Bethelview Office
2320 Bethelview Rd Ste 105
Cumming GA 30040
Phone (770) 203-1000
Fax (770) 886-9908

Medical Record Release Request

To:

Physician ______________________________

Address ______________________________

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Phone ______________________________

Fax ______________________________

Dear Doctor,

I hereby authorize and request you to release my / my child's complete medical records in your possession to:

Old Atlanta Office
3030 Old Atlanta Rd, Suite 500
Cumming GA 30041
Phone (770) 203-2000
Fax (770) 886-7903

Bethelview Office
2320 Bethelview Rd Ste 105
Cumming GA 30040
Phone (770) 203-1000
Fax (770) 886-9908

Patient Name: ______________________________

Date of Birth: ______________________________

Signature ______________________________ Date ________________