AUTHORIZATION & REQUEST FOR MEDICAL RECORDS

I_________________________________ DOB:__________________, hereby request that my medical records be released to/from Performance Orthopaedics and Sports Medicine.

Release To / From (Please Circle One):

Name/Practice: Performance Orthopaedics & Sports Medicine

Address: 3280 Howell Mill Road Suite 205 Atlanta, GA, 30327

Phone: 404-973-2444 **Fax: 404-935-9832**

Release To / From (Please Circle One):

Name/Practice:

Address:

Phone: **Fax:**

Items Released:

___Entire Medical Record **___X-Rays** **___Surgery /Diagnostic Reports**

Patient/Guardian Name Printed:____________________________________ **Date:**

Patient/Guardian Signature: ____ **Date:**

[Type here]