



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]

Locations

Atlanta Office

3280 Howell Mill Road NW.
Suite 205
Atlanta, Ga 30327

Lawrenceville Office

631 Professional Drive
Suite 170
Lawrenceville. GA 30046

Villa Rica Office

845 South Carroll Road
Villa Rica, GA 30180

Phone (404) 973-2444

Fax (404) 935-9832