North Atlanta Heart & Vascular Center, P.C.
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REQUEST FOR RELEASE OF MEDICAL RECORDS

This form to be used if we need to get records from a previous physician or previous hospital stay

Only complete bottom portion of this form

TO:

_____

_____

_____

I hereby request that all my medical records be released to North Atlanta Heart & Vascular Center, P.C. as soon as possible.

Please Print

Patient Name:_____ **Date:**_____

DOB:_____ **SSN:**_____

Address:_____

_____

_____

Patient Signature:_____

Witness:_____