ATLANTIC ORTHOPAEDICS, P.A.

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REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby request that my medical records be released from:

Atlantic Orthopaedics, P.A.
314 Franklin Avenue, Suite 105B
Berlin, MD 21811
410-641-1900
410-641-9473 (Fax)

To: (Please include practice name, address, telephone number and fax number)

_____
_____
_____
_____
_____

Please include the following for _____ (Body Part), starting with the date of_____:

_____ Progress/Office Notes

_____ History and Physical

_____ Test Results (Including Labs, X-rays, MRI, CT Scan, EMG)

_____ Operative Notes

_____

Patient Name Patient Date of Birth

_____

Patient Signature Date of Request

_____

Signature of Patient Representative Relationship