

ATLANTIC ORTHOPAEDICS, P.A.

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REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby request that my medical records be released to:

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

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