REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby request that my medical records from Atlantic Orthopaedics, P.A. be released to:

____
(Physician's Name)

____
(Street Address)

____
(City) (State) (Zip Code)

____
(Telephone Number) (Fax Number)

____
(Patient Name)

____
(Patient Signature)

____
(Patient Address)

____
(City) (State) (Zip Code)

____
(Patient Date of Birth) (Patient Social Security Number)