ATLANTIC orthopaedic group

1341 Medical Park Drive, Suite 201
Melbourne, Florida 32901
Phone: (321) 768-9914 Fax: (321) 722-0070

MEDICAL RECORDS RELEASE

You are entitled to a copy of your medical records *once* a year – free of charge. We have 30 days to process your record request. We will process them as soon as possible.

Date Requested:
Account #
Patient Name:
Date of Birth:
Contact #

FROM DOCTOR:

- ☐ John Hermansdorfer, MD
- ☐ Paul Keller, MD
- ☐ Robert Cooper, MD
- ☐ Ronald Stern, MD
- ☐ John J. Perry, MD
- ☐ Other:_____

I HEREBY REQUEST THE FOLLOWING INFORMATION

☐ Office Notes	☐ Operative Report	
☐ Labs	☐ X-Ray Report	
☐ Billing	☐ X-Ray Films	☐ Other_____

PLEASE SEND TO: ☐ Self ☐ Attorney ☐ Treating Doctor ☐ Insurance Company ☐ Atlantic Orthopaedic Group

MAILING ADDRESS:

_____
Name

_____
Street Address

_____
City State Zip

_____ _____
Phone Fax

By signing this form, I request and authorize the release of the medical information noted above including information concerning HIV, Hepatitis, STDs, Addictions and Mental Illness. This authorization is valid for lifetime use unless revoked in writing.

X_____
Signature **Date**