

Midtown Neurology, P.C.

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**I hereby request medical records in paper or CD format for the patient below
(Please send larger medical records on a CD, if your facility has the capability)**

Patient Name: _____ **Chart:** _____

SS#: _____ **DOB:** _____

You are hereby authorized to release copies of:

Office Notes _____ **Lab Reports** _____ **X-Ray Reports** _____

All Records _____ **Other:** _____

From:

To: Midtown Neurology, PC

**285 Boulevard NE
Suite 345
Atlanta, GA 30312**

Signature: _____ **Date:** _____

**Have you been a hospital patient at Atlanta Medical Center (AMC)
in the past year?**

_____ **YES** _____ **NO**