DR. RANA MUNNA
INTERNAL MEDICINE

T: 478-238-0771 | F: 478-238-6688

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: _____

Patient: _____

Date of Birth: _____

REQUESTING MEDICAL RECORDS FROM:

Physician: _____

Address: _____

Office Phone #: _____ Fax: _____

TO WHOM IT MAY CONCERN:

Please send all medical records, including office visit, laboratory studies, radiologic studies, EKG reports and hospital admission records on the above patient for the purpose of treatment.

If more information is needed, please contact our office. Thank you.

PATIENT SIGNATURE: _____