Pulmonary and Sleep Medicine Center of Winder

20 Satellite Dr. Ste 200, Winder, GA 30680
Phone (770) 586-0300, Fax (770) 586-0311

Medical Records Request Form

Patient Name: _____ Date of Birth ____ / ___ / _____
Last First Middle

Address_____
Street City State Zip

What type of medical records do you need? (Check one below)

☐ Entire Medical Records
☐ Other:

_____

I, the signed patient or legal guardian of patient authorize Pulmonary and Sleep Medicine Center of Winder to release my records to:

_____
(Name of Physician, Medical Practice, or Treating Hospital)

_____
(Address of Facility) (City) (State) (Zip)

_____
(Telephone #) (Fax # - Very Important)

By: ☐ Fax ☐ Mail ☐ Patient will pick up the records at our office

_____
Signature of Patient or Legal Guardian Date of Birth

_____
Print Name of Patient or Legal Guardian Date