Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:
Social Security Number:	Hospital: Select Hospital:		

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ____/____/____ through ____/____/____

☐ Discharge Summary ☐ Emergency Room Records ☐ Operative/Procedure Reports ☐ Billing Records

☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

☐ Other (Immunization Records, Medication Lists) Please specify: _____

Where do you want the information sent? (Fill in boxes below):

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship (please print)**
Signature of Patient or Personal Representative	**Date/Time**

Please return completed form and a $25 payment to:

GlassRatner Advisory & Capital Group
Attn: Laura Clemente
3445 Peachtree Road NE, Suite 1225
Atlanta, GA 30326