



Northview Orthopaedic Associates

Orthopaedic Surgery | Open MRI | Ambulatory Surgery Center

Return completed form by mail to 70 Ansley Drive, Dahlenega, GA 30533

or email to: medicalrecords@northviewortho.com

RECORDS REQUEST

Patient Information

MRN # _____

PATIENT NAME		DATE OF BIRTH	LAST 4 OF SS#
ADDRESS	CITY	STATE	ZIP

Check here to send records to you at the above address OR complete below in full to send records to another physician.

OFFICE NAME	CONTACT NAME	TREATING DOCTORS NAME	
ADDRESS	CITY	STATE	ZIP
PHONE	FAX		

What Records Should be Released?

DATE(S) OF SERVICE _____

- | | | |
|---|---|--|
| <input type="checkbox"/> All Records | <input type="checkbox"/> X-Ray / MRI Report | <input type="checkbox"/> X-Ray / MRI Discs |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation (s) | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Other | | |

What Format and Delivery Method Would You Prefer?

Format: Paper CD PDF

Delivery Method: Mail Pick-up (prior to December 22, 2023) Fax Email

- I hereby authorize Northview Orthopaedic Associates to disclose/release medical records and/or other information obtained during my diagnosis and/or treatment.
- I hereby release Northview Orthopaedic Associates from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

DATE

IF SIGNED BY LEGAL REPRESENTATIVE, **RELATIONSHIP** TO PATIENT:

IN OFFICE USE: DATE REQUEST RECEIVED:

DATE PROCESSED:

Please allow 3-4 weeks to receive non-urgent records.