Atlantic
Medicine & Wellness

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Phone: (732) 528-5533 Fax: (732) 528-0360

Medical Records Request Form

Patient Name: _____

Date of Birth: _____

Date Requested: _____

Please select the documents that apply to your request:

Clinical Notes ☐ Radiology Reports ☐ Lab Reports ☐ ALL ☐

Additional details: _____

Requested By: Patient { }

Other { } _____

Delivery Method:

Mail: { } Address _____

_____

Email: { } Email Address: _____

Pick up: { }

Please Note: All fees must be paid in full prior to our office sending out any medical records. Please expect a 2-week turnaround time from the requested date.

Patient Signature: _____Date: _____