



Chart # _____

Dr. Michael J. Kalson ♦ Dr. Jesse E. Seidman

318 Tribble Gap Rd.
Cumming, GA 30040
770-889-0891 Fax 770-889-0354

3929 Carter Rd.
Buford, GA 30518
770-271-9855 Fax 770-271-1118

3540 Duluth Park Lane
Ste.220 Duluth, GA 30096
770-476-1900 Fax 770-476-1753

(Please check the office you were treated in)

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

I here by request the following information:

- Medical Records (Will Be Invoiced)
- Billing records (\$20.00 Fee)
- X-ray CD/Copies (\$15.00 Fee)
- Other _____ (Specify item requesting)

I here by authorize Academy Orthopedics, LLC to release medical records as indicated above and understand that records may include information regarding HIV, psychiatric and mental illness, drug/alcohol abuse records, venereal disease and any other statutory protected diseases. Please note that this service is outsourced to Health Port, a records duplication company and there will be a charge for your records based on the volume of pages.

Patient /Guardian Signature

Date

Witness Signature

Date

MAIL RECORDS TO:

Name of Practice/Company/Attorney: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____