Crabapple Medical Center PC

PRIMARY CARE & GERIATRICS

Care with Compassion

Request for Medical Records

Name of Medical Practice: _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ - _____ - _____ Phone Number: (____) ____ - _____

Date Requested: _____ / _____ / _____

Reason: _____

Requested By: [ ] Patient [ ] Physician [ ] Other _____

Please Disclose Records To:

Crabapple Medical Center
282 Rucker Rd
Suite 140
Alpharetta, GA
T: (770) 360-9484 | F: (770) 360-9483
crabapplemc@gmail.com

Please include the following documents:

- ☐ Clinic Notes
- ☐ Progress Notes
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Radiology Reports
- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Urgent Care
- ☐ Nurse Notes
- ☐ EKG, EEG, EMG
- ☐ Emergency Room
- ☐ Doctor Consults
- ☐ Physician Orders
- ☐ Other _____