MEDICAL RECORDS REQUEST FORM

Patient Name: ________________________________ Date of Birth: ____________

SEND INFORMATION TO (ENTITY):

Facility Name 1:____

Doctor's Name:____________________________ Specialty:___________________

Fax Number:______________________ Phone Number:______________________

Facility Name 2:____

Doctor's Name:____________________________ Specialty:___________________

Fax Number:______________________ Phone Number:______________________

Facility Name 3:____

Doctor's Name:____________________________ Specialty:___________________

Fax Number:______________________ Phone Number:______________________

Facility Name 4:____

Doctor's Name:____________________________ Specialty:___________________

Fax Number:______________________ Phone Number:______________________

Facility Name 5:____

Doctor's Name:___________________________ Specialty:___________________

Fax Number:______________________ Phone Number:______________________

VAC Wound Care GA
1186 Satellite Blvd., Suite 200, Suwanee, GA 30024
records@vacwoundcarespecialists.com
Phone: (770) 614-6266
Fax: (678) 392-4827

****VAC wound Care GA kindly requests all Medical Records for the above**

patient.** Should you have any questions, do not hesitate to contact our office at **770-614-6266.**

Patient Signature ______________________________Date _________________

○ By checking the box, I authorize the release of my medical records to VAC Wound Care GA.