



MEDICAL RECORDS REQUEST FORM

(Please use this form for any specialty forms needing to be completed)
(I.e. Insurance forms, disability forms, physical forms, etc.)

I. Personal Information

Patient Name: _____
(First Name) (Middle) (Last)

Street Address: _____
(Mailing Address)

(City) (State) (Zip)

1. Home Phone: _____ 2. Work Phone: _____
3. Mobile Phone: _____ E-mail: _____

II. Type Of Informations Needed

- 1. Please attach any forms needing to be filled out (Attach to this Form)
- 2. If you do not have any forms, please describe what you are needing in detail

III. Please fill in where the information needs to go

- A. Patient Will Pick up at our office _____ (please check)
- B. Our office will mail this information to the below address _____ (Please check)

Name: _____
(Practice, Individual, or Insurance Company Name etc)

Address if Mailing: _____
(Street Address)

(City) (State) (Zip)

C. Our office will fax the information where it needs to go: _____ (Please Check)

Fax Number: _____
(If it needs to be sent via Fax)

Date Information is due: _____

IV. Payment:

Please note our office needs to charge \$25.00 for each form filled out due to the time these forms take to fill out.

We will submit these forms once payment has been received either by check or credit card called in.

Thank you for your understanding

(Signature of Patient or Guardian)

(Date of Signature)

(Print Name)

V. Office Use Only

(Individual who handled request)

(Date completed)

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