ROBINSON FACIAL
PLASTIC SURGERY
Burke Robinson M.D.

MEDICAL RECORDS REQUEST FORM

Patient's Name: _____

DOB: _____

I hereby authorize the office of **Burke P. Robinson, MD, F.A.C.S.** to release my medical information to the following:

Patient/ Guardian: _____

Or to the following:

Practice/ Doctor's Name: _____

Phone: _____ Fax: _____

Address: _____

Information to be released: _____

_____

This authorization is subject to my written cancellation at any time.

_____ _____

Signature of Patient/ Guardian Date

_____ _____

Witness Date

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ATLANTA OFFICE: 5555 Peachtree Dunwoody Road | Suite 155 | Atlanta, GA 30342
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