ADVANCED FOOT AND ANKLE
INSTITUTE OF GEORGIA LLC
SPECIALISTS IN RECONSTRUCTIVE FOOT AND ANKLE SURGERY

REQUEST FOR PATIENT FILE

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____

_____

I hereby request a copy of the sections of my patient file listed below be forwarded to

_____

_____

_____
(Name and address of the practice to receive the information)

Entire file: _____

Specific sections:

1. _____
2. _____
3. _____
4. _____

Signature of Patient: _____ Date: _____

Signature of
Practice Representative: _____ Date: _____