Rehabilitation Physicians of Georgia, P.C.

Sebastiaan M. Bens, D.O.
Dayna J. London, M.D.
Lisha Davis, P.A.-C
Tamara Harris, P.A.-C
Meredith Magner, P.A.-C
Kenneth Obimpeh, P.A.-C
Adonness Bell, NP-C
Martha Friedl, NP-C
Rebecca Jill Pope, NP-C

Mark W. Feeman, D.O.
Medical Director

Ernest L. Howard, M.D.
Medical Director

Mark F. McGreevey
Chief Executive Officer

Ajori N. Burkhammer
Executive Director of Operations

REQUEST FOR MEDICAL RECORDS

Date: ______________

I, _________________________ request that _________________________Fax#_______________, Fax my medical records to Rehabilitation Physicians of Georgia. I understand that these records contain protected health information.

Patient Name: ____

Patient Signature: ______________________________________

Patient Date of Birth: ____________________________________

Patient Contact Number: _________________________________

Date of Request: ____

Please include the patient's demographic information, last 3 office notes,, diagnostics reports, urine drug screens, and discharge letter if applicable. Thank you!

Please fax requested information to:
Rehabilitation Physicians of Georgia, PC
Attn: Victoria - New Patient Coordinator
Fax 770-399-9449

Back and Neck Pain Specialists
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Administrative Offices: 2450 Atlanta Highway • Suite 904 • Cumming, Georgia 30040 • Phone: 404-659-5909 • Fax: 770-399-9449
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