

Atlantic **M**edical **P**hysicians

Primary Care Injury Centers

1500 Allaire Avenue, Suite 103
Ocean, NJ 07712

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Board Certified

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MEDICAL RECORD RELEASE FORM

Dear _____:

Office Phone: _____

Please release my medical records to:

**Atlantic Medical Physicians
1500 Allaire Avenue, Suite 103
Ocean, NJ 07712**

Thank you.

Patient's Name: _____

Date of Birth: _____

SSN: _____

Patient's Signature

Date