Atlanta Cardiology Consultants, P.C.
Thomas S. Backer, M.D., F.A.C.C. / Katie Steffen, MMSC PA-C

Medical records release form:

Patient Name: _____ Date Of Birth: _____

I, _____ hereby authorize _____ to release my medical records to: Fax: _____

Facility/Doctor Name:	Atlanta Cardiology Consultants/ Thomas S. Backer, M.D., FACC
Facility Address:	3400 Old Milton Pkwy, Building C, Suite 395 Alpharetta, GA 30005
Facility Phone:	770-751-9131
Facility Fax:	770-751-9132 or 770-751-9945

Information to be released/obtained:

___ All Records ___Last office visit ___Echo report
___ Most recent LABS ___EKG ___Stress Test Report
___ Other: _____

_____ _____
Signature of patient Date Signed