



REQUEST FOR MEDICAL RECORDS

Patient Name _____

Address _____
Street City State Zip

Telephone _____

Fax _____

Email _____

Relationship to the Medical Records

Self Authorized Relative Attorney Insurance Company

Other _____

You or your authorized representative must

- Pick up records at 2731 Napoleon Avenue, New Orleans, LA, 70115
- You must provide a valid authorization to release.
- You must provide state or federal produced picture identification.
- Fee must be paid prior to or at the pick up time.
(Prior to your pick up our office will call you and advise you of the costs of records.)

*Proper documents must be on file for us to release medical records.

Print, complete and fax/email to:

Fax: (504) 899-7317 • Email: Main@southern-ortho.com