Arun K. Kantamneni, MD, Psychiatrist
Darshan A. Patel, MD, Psychiatrist

MEDICAL RECORD REQUEST

Name: ____

DOB: ____________ **Date:** ____________ **Best Contact #:** ____________________

FEES:

Patient Record Request	$30.00
DFCS Record Request	$30.00
Attorney Record Request	$30.00
Insurance/Disability Request	$30.00
Doctor's Office Request	$0.00

OFFICE STAFF ONLY:

Approved: ______ Denied: ______

HOW TO SEND:

FAX: ______________________________

Email: ______________________________

Mail: ______________________________

City: ____________________ State: ______ Zip Code: __________

Pick- Up: ______________________________

PAYMENT TYPE:

____ Cash

____ Postal Money Order

____ Credit Card Credit Card Number: ____________________

Expiration Date: _____/_____ Security Code: ________

TOTAL AMOUNT COLLECTED: __________

We accept payment via credit card, debit card, or cash. We do not accept personal checks. Do not send cash in the mail.

Every effort will be made to complete your forms as soon as possible. However, please allow **7-10 business days** for completion.

p: 770-858-5377 | f: 770-874-3310
4125 Atlanta Road SE, Suite 120 | Smyrna, GA 30080