Mir Neurology
NeuroSpine Center

MEDICAL RECORDS REQUEST

I _____ DOB: _____ hereby request to have my medical records from Mir Neurology and Spine Center sent to:

Facility/Name: _____

Department: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

If you have any questions, please feel free to contact us at 301-797-7600

Signed (patient/guardian)_____Date_____

This form must be signed by the patient or by the legal guardian in the case of a minor or physically/cognitively disabled adult.

11110 Medical Campus Rd., Suite 151
Hagerstown, MD 21742
Phone: 301-797-7600

924 Seton Drive, Suite C
Cumberland, MD 21502
Phone: 301-797-7600