J. BRANDON MORGAN, M.D.
GENERAL SURGERY

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Medical Records Request Form

First: _____Middle: _____ Last: _____

Date of Birth: _____ SSN: _____

Previous Last Names/Maiden Name:_____

Records Requested:

- All records in specific date range. From ____/___/____ To ___/___/____
- Complete medical record
- Specific operative and pathology listed below

  _____

  _____

Where to Send Records:

Name of Doctor/Facility: _____

Address: _____

Telephone: _____ Fax:_____

Method of Transmission:

- Fax: _____
- Email:_____
- Mail via USPS: _____

For all urgent requests: please call or text the office directly at 870-881-9311