



Monica Hum MD • FACS • FASCRS
Tonya Jordan MD
Joseph Mareno Jr. MD

Date: _____

Dear Dr. _____

I hereby request that my medical records be released to
Dr. Monica Hum
95 Collier Road Suite 4025
Atlanta, GA 30309
Tele: (404) 574-5820
Fax: (404) 574-5821

Patient's Name: _____

Date of Birth: _____

Specify Records (circle relevant choices):

Please send my entire record over

Please send these parts of my record: H & P

Colonoscopy reports

Pathology reports

CT scan reports

X-Ray studies

Operative reports

Last office note

Patient's Signature: _____