

MARBLE VALLEY HEALTHWORKS

8 Commons Street, Rutland, VT 05701

Phone: 802.770.1805

Fax: 802.773.4876

Future Appt: YES NO

[] kept [] cancelled

MEDICAL RECORDS REQUEST AUTHORIZATION FORM

PATIENT Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

_____ Doctor: _____

I hereby authorize the medical offices of Bruce Bullock, MD, PC and Seth Coombs, MD, PC to:

[] RELEASE MY MEDICAL RECORDS TO:

[] OBTAIN MY MEDICAL RECORDS FROM:

MD/FACILITY: _____ Phone #: _____

Address: _____ FAX #: _____

_____ Email #: _____

INFORMATION REQUESTED/TO BE RELEASED:

[] Initial Examination

[] Special Procedures

[] Office Visit Notes

[] Mental Health/Substance Abuse

[] LABs

[] X-RAYS

[] **COMPLETE RECORD**

CONFIDENTIAL INFORMATION AUTHORIZATION:

I understand that any information released is confidential and protected by law. This law prohibits further disclosure of this information without specific written consent of the patient.

[] I am transferring my care to a new primary care office,
effective _____, 20____.

Patient Signature: _____ Date: _____
(or Authorized Legal Representative)

Witness: _____

MD Approval: _____