MARBLE VALLEY HEALTHWORKS

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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 :

[ ] RELEASE MY MEDICAL RECORDS TO:
[ ] RELEASE MY MEDICAL RECORDS FROM:

MD/FACILITY:____ Phone #:__________________

Address: ____ FAX #: ____________________

____ Email #: ___________________

INFORMATION REQUESTED/TO BE RELEASED:

[ ] Initial Examination
[ ] Office Visit Notes
[ ] LABs
[ ] X-RAYS

[ ] Special Procedures
[ ] Mental Health/Substance Abuse

[ ] 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 also understand if my records are transferred to another practice per my request, I will no longer be a patient of this practice effective __________________________, 20_____.

Patient Signature: ____ Date: ________________
(or Authorized Legal Representative)

Witness: ____

MD Approval: ____________