9 Commons Street, Rutland, VT 05701

Phone: 802.779-7522
Fax: 802-735-9662

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 True Care Vermont :

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

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: _____