Request for Transmittal of Medical Records
Gary M Gross MD
Huntsville Vascular Specialists PC

Patient Name:

Email address: Date of Birth:

Home Phone: Cell Phone:

Street Address:

City/State: Zipcode:

Your Signature:

or if unable to sign, Signature, Relation, and
Name of Family Member requesting:

I authorize and am requesting a copy of my pertinent office health records from Dr. Gross.
Deliver to
Name of Doctor:

Doctor Address:

Doctor Phone Number:

Doctor Fax Number (if available):

I request records to be sent by (choose one):

_____Fax (no charge before February 28, 2019) _____Mail a copy (Enclose $20)

Send this form to Huntsville Vascular Specialists PC
PO Box 18844
Huntsville, AL 35804-8844