

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