RUTLAND SKIN CENTER

Daniel P. McCauliffe, M.D.
3 Mahoney Avenue
Rutland, VT 05701
Phone: (802) 773-3553
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Medical Records Transfer Request Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

I, _____, request that my medical records be transferred to me (or _____) so that I can take them to my first appointment with my new dermatology provider at: _____

Date of my appointment with my new dermatology provider: _____

or

I, _____, request that the Rutland Skin Center transfer my records to Dr. Elizabeth Foley. I have received a copy of the instructions how Dr. Foley's office will schedule my appointment.

_____ _____
Signature Date