Pain & Spine Center of the Desert

Mark Bouffard, M.D.
Board Certified in PM&R

MEDICAL RECORDS RELEASE FORM

In order to ensure that your medical records are held in the utmost confidentiality please complete form in its entirety so that we may obtain proper records.

Name:_____ **Date of Birth:**_____
Address:_____ **Home Phone:**_____
_____ **Work Phone:**_____
_____

Please transfer my Medical Records:

To/From: _____ **To/From:** **Mark Bouffard, M.D.**
_____ 72650 Fred Waring Dr., #214
_____ Palm Desert, CA 92260

Please specify which Medical Records you want released:
Please leave this section blank so that we way obtain any records necessary.

_____ X-Rays/MRI _____ Demographics _____ Ins. Info

_____ All Medical Records _____ Office Notes/OP Reports

_____ Other

I understand that my Medical Records are protected under State and Federal Confidentiality regulations and will be obtained for office use only.

_____ _____
Patient signature Date

72650 Fred Waring Dr., Suite 214
Palm Desert, CA 92260
Phone: (760) 776-7999 Fax: (760) 776-7994