

PURE Center for Integrated Health

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HEALTH CARE INFORMATION

Primary Care Provider: _____ Office Location: _____ Phone: _____

Was this visit pre-approved? Yes No

Other Provider: _____ Office Location: _____ Phone: _____

Was this visit pre-approved? Yes No

Other (i.e. Worker's Comp, Attorney, etc.): _____ Office Location: _____

Phone: _____ Was this visit pre-approved? Yes No

Medical Records Release: By signing below, I authorize Dr. Bruns and her staff to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed above for the purpose of insuring I receive proper treatment.

Print Patient's name: _____ **Today's Date:** _____

Patient or Guardian's signature: _____ **Patient's Date of Birth:** _____