Minimally Invasive Surgical Solutions

455 O'Connor Drive, Suite 390 San Jose, CA 95128 Tel: 408-918-0405 Fax: 408-918-0409 www.endovascularsurgery.com

CONSENT TO RELEASE MEDICAL INFORMATION

Patient's Name: (Last) (First)

Date of Birth:

Address: Phone:

City/State/Zip:

I hereby authorize:

_____

Physician/Facility:

_____

Address:

_____

City/State/Zip:

_____

To release records obtained in the course of my diagnosis and treatment to:

Minimally Invasive Surgical Solutions
455 O'Connor Drive, Suite 390
San Jose, CA 95128

Patient's Signature: _____Date: _____

Or Guardian of Patient: _____Date: _____

Relationship: _____

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