

CARDIOVASCULAR CONSULTANTS MEDICAL GROUP

Consultative and Interventional Cardiology

Cardiac Electrophysiology

Peripheral Vascular Disease

A Partnership of Medical Corporations

www.healthyhearts.com



AUTHORIZATION TO RELEASE RECORDS

DATE: _____ RECORDS NEEDED BY: _____

To: Cardiovascular Consultants Medical Group

- 16542 Ventura Blvd, Suite 402, Encino, CA. 91436 818.782.5041 ph 818.205.9091 fax
- 14901 Rinaldi Street, Suite 110, Mission Hills, CA. 91345 818.365.1339 ph 818.898.4301 fax
- 10921 Wilshire Blvd, Suite 1205, Los Angeles, CA. 90024 310.824.3378 ph 310.208.2870 fax
- 23929 McBean Pkwy, Suite 216, Valencia, CA. 91355 661.259.1534 ph 661.284.3670 fax

I hereby authorize and request you to release copies of my medical records to:

_____ Myself

Specific information requested:

(Patient's Name)

(Date of Birth)

(Signature)

(Social Security Number)