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: _____

_____

_____

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

Cardiovascular Consultants Medical Group ATTN: _____

□ 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

Specific information requested:

_____

_____

_____ _____
(Patient's Name) (Date of Birth)

_____ _____
(Signature) (Social Security Number)