BERKELEY CARDIOVASCULAR MEDICAL GROUP

Main Office • 3300 Webster Street • Suite 702 • Oakland • California • 94609
(510) 549-4220 • FAX (510) 433-0744 • www.bcvmg.com

Cardiac Testing Office • 3300 Webster Street • Suite 702 • Oakland • California • 94609
(510) 549-4220 • FAX (510) 433-0744

Lafayette (satellite office) • 3466 Mt. Diablo Blvd. Ste. C-100 • Lafayette • California • 94549
(925) 283-3300 • FAX (510) 433-0744

John S. Edelen, M.D., F.A.C.C.
Luisa Muñoz, M.D., Ph.D
Robert M. Greene, M.D., F.A.C.C.
Duane D. Stephens, M.D., F.A.C.C.
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Authorization to Disclose Patient Medical Records

I authorize: _____
_____
_____

To disclose to: _____
_____
_____

Medical Records Requested: _____
_____
_____

_____
Patient Name Date of Birth

_____
Patient Signature

_____
Expires on

Mail records to: _____
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