Authorization for
Release of Medical Information

I hereby authorize and request Dr. _____ to furnish any or all information concerning my past and present medical history and condition to:

South Bay Vascular Center
2255 South Bascom Avenue Suite 200
Campbell, CA 95008

Tel: 408-376-3626 • Fax: 408-871-2377

Patient Name (Please Print): _____ Date of Birth: _____

Home/Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date:_____

Witness: _____