Dr. Siddhartha Rao
Vascular Solutions

P: (919) 897-5999

Authorization for Release of Medical Records

Patient Information

Name:		
Date of Birth: / /		Social Security:
Street Address:		
City:	State:	Zip:
Phone: ( )		

Physician's Office Information

Name:		
Address:		
City:	State:	Zip:
Phone: ( )		

I REQUEST MY MEDICAL RECORDS TO BE RELEASED TO:

VASCULAR SOLUTIONS OF NORTH CAROLINA
1000 CRESCENT GREEN, SUITE 102
CARY, NC 27518

PHONE: (919) 897-5999
FAX: (919) 897-5980

By my signature, I authorize release of my medical records.

Signature: _____ Date: _____