VEINSPECIALISTS
OF NORTHERN CALIFORNIA
Mark N. Isaacs, M.D.

Authorization for Release of Medical Records

To: ____

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Please release my medical records to the person or organization named above. I understand there is a fee of $35.00 for these records which may be paid via check to Mark N. Isaacs, M.D. Inc.
I am enclosing a copy of my driver's license or state issued ID as proof of identity.

Patient Name (print):______________________________

Patient Signature:_________________________________

Date of Birth: ____________________________

Date:____________________

Revised 01/16/19 agh