



General, Vascular, Thoracic Surgery  
Et Advanced Laparoscopic Surgery

Certified Noninvasive Vascular Lab

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## Medical Record Release Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*I authorize the release of information and records regarding my examination,  
diagnosis and treatment to/from:*

The Surgical Care Group, PC  
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Manchester, NH 03102  
Phone: 603.627.1887  
Fax: 603.627.1890

To: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_