DESERT
VEIN AND VASCULAR
INSTITUTE

MEDICAL RECORDS REQUEST

Patient Name _____

Date of Birth _____

The above patient is under the care of Desert Vein and Vascular Institute.
Please forward the following information from their medical record:

- Consult Reports, Operative Reports, Discharge Summaries
- X-ray, CT, MRI, Ultrasound, and any other imaging studies

I hereby authorize the requested information contained in my medical record be forwarded to:

Desert Vein and Vascular Institute
71780 San Jacinto Drive, Bldg. I
Rancho Mirage, CA 92270
Phone: (760) 568-3461
Fax: (760) 423-6273

Patient Signature _____ Date _____