



RECORDS RELEASE AUTHORITY

To _____

I, _____ hereby request that you release to:

VALLEY MEDICAL ONCOLOGY CONSULTANTS

- 5725 West Las Positas Boulevard, Suite 100, Pleasanton, CA 94588 – (925) 734-8130 Fax (925) 734-8130
- 20055 Lake Chabot Road, Suite 130, Castro Valley, CA 94546 – (510) 888-0657 Fax (510) 886-4532
 - 1999 Mowry Avenue, Suite H, Fremont, CA 94538 – (510) 794-5320 Fax (510) 794-1242
 - 27206 Calaroga Avenue, Suite 201, Hayward, CA 94545 – (510) 887-4074 Fax (510) 670-1047
 - 13847 E. 14th Street, Suite 201, San Leandro, CA 94578 – (510) 888-0659 Fax (510) 886-4532
- 5401 Norris Canyon Road, Suite 306, San Ramon, CA 94583 - (925) 830-9293 Fax (925) 225-9520
- 2490 Hospital Drive, Suite 111, Mountain View, CA 94040 – (650) 988-8338 Fax (650) 962-4594

A report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from _____ to _____.

(Date of Request)

(Patient's Signature)

(Witness)

(Address)

(Address)

(Date)

(City, State, Zip Code)