

Michael A. Vasquez, M.D., F.A.C.S., R.V.T.

Glenn Buczkowski, RPA-C

Esther Sprehe, ANP

GENERAL AND VASCULAR SURGERY

Date: _____

I, _____ Hereby give
my permission for release of a copy of my medical records from
Dr. _____ to
**Dr. Michael Vasquez at 415 Tremont St, N Tonawanda, NY
14120.**

Date of Birth: _____

Former Name: _____

Address at time of service rendered:

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Patient Signature: _____

Witness Signature: _____

Date: _____