

**CENTER FOR HEALTH & CANCER PREVENTION**  
**Keith Berger, MD**

1301 First Colonial Rd  
Suite 201  
Virginia Beach, VA 23454  
Phone 757-412-4919  
Fax 757-412-4898

**MEDICAL RECORDS RELEASE**

Patient Name \_\_\_\_\_  
Last First M.I. Maiden

Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_

**\*Authorization to release medical information  
to your Primary Care Physician and/or your Insurance Carrier only  
is hereby given to  
Dr Keith Berger with the Center for Health & Cancer Prevention**

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Signature of Patient or Guardian

\_\_\_\_\_  
Date

\*Authorization is effective until revoked by the patient.