BOULDER OMS
ORAL AND FACIAL COSMETIC SURGERY

LA JOLLA
ORAL AND FACIAL SURGERY

12630 Monte Vista Road, Suite 205
Poway, CA 92064
O: 858.485.1290
F: 858.675.7485

7855 Fay Avenue, Suite 240
La Jolla, CA 92037
O: 858.459.0862
F: 858.459.2045

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize you to give all information regarding my medical care, including x-rays and laboratory results to:

_____

For Dates of Treatment: _____

Received at the following office: □ Boulder OMS □ La Jolla OFS □ Both

Treating Doctor: □ Dr. Albert W. Lin □ Dr. Robert T. Gramins

This authorization will remain valid for one (1) year from the date of signature unless revoked in writing by the patient. I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original.

_____

Printed Patient Name Date of Birth

_____

Patient Signature

_____

Parent or Guardian Signature

_____

Relationship to Patient

_____

Today's Date Witness