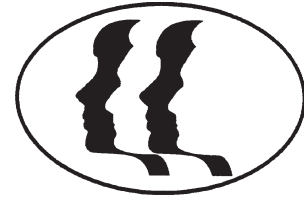


Oral & Facial Surgery Center
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO WHOM IT MAY CONCERN:

I hereby authorize any physician, surgeon, hospital, ambulance owner, nurse and any other person, organization or insurance company to furnish any and all records, information and evidence in their possession regarding _____ injuries, medical history and physical condition.

Upon presentation of this authorization or an exact photo or facsimile thereof, you are directed to permit the personal review, copying or photostatting of such records.

X

Signature

Date