

Osborne Head & Neck Institute
and
Osborne Head & Neck Specialty Group

□ **Dr. Ryan F. Osborne**

AUTHORIZATION TO RELEASE RECORDS

To:

Name:	
Address _____ _____ _____	
Phone:	Fax:

Please release the following Medical Records to:

OSBORNE HEAD AND NECK INSTITUTE
and
OSBORNE HEAD AND NECK SPECIALTY GROUP

8618 S. Sepulveda Blvd 3rd Floor
Los Angeles, CA 90045

___ All Medical Records
___ Imaging Studies/Reports
___ CD/Photo

___ Other _____

Print Patient's Name

Date of Birth

Signature of Patient/Guardian

Date

Osborne Head & Neck Specialty Group

8 618 S. Sepulveda Blvd 3rd Floor
Los Angeles, CA 90045
310 657-0123 Tel

310 657-0142 Fax