366 Broadway Suite 100
Somerville, MA 02145

CRANIOMAXILLOFACIAL
SURGERY ASSOCIATES

T (617) 628-8000
F (617) 628-2370

Medical Records Release Form

Dr. Timothy Osborn, M.D.,D.D.S., FACS & Dr. Eva Wardius, DMD, CAGS

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:_____ Date of Birth:_____Phone #:_____

The information you may release subject to this signed release form is as follows:

____complete records	____History & Physical	____Progress Notes
____care plan	____Lab Reports	____Radiology Reports
____Pathology Reports	____Treatment Record	____Operative Reports
____Hospital reports	____Medication Record	____Other (please specify below)

Release my protected health information to the following physician, person, facility, entity and/or those directly associated in my medical care:

Name:_____

Address:_____

City: State: Zip Code:_____

The purpose/reason for this release of information is as follows:

_____

Signature:_____ Date_____