

# ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, LTD.

Fred A. Menghini, DDS, MD  
Diplomate, American Board of  
Oral & Maxillofacial Surgery



John S. Foss, DDS, MD  
Diplomate, American Board of  
Oral & Maxillofacial Surgery

Dental – alveolar surgery  
Implant surgery  
Maxillofacial trauma surgery  
Maxillofacial reconstructive surgery  
Oral and maxillofacial pathology

Courtney A. Anderson, DDS  
Diplomate, American Board of  
Oral & Maxillofacial Surgery

## AUTHORIZATION OF RELEASE OF PATIENT RECORDS

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SSN: \_\_\_\_\_

### RECORDS SENT TO DOCTOR, CLINIC OR ATTORNEY:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

### PATIENT INFORMATION REQUESTING:

\_\_\_\_\_ RADIOGRAPHS \_\_\_\_\_ DOCTOR NOTES \_\_\_\_\_ BIOPSY NOTES \_\_\_\_\_ RECORDS FOR CONTINUING CARE

I AUTHORIZE ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES LTD TO RELEASE MY RECORDS TO THE ABOVE MENTIONED DOCTOR,  
CLINIC OR ATTORNEY.

\_\_\_\_\_ DATED \_\_\_\_\_

SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

\_\_\_\_\_ DATED \_\_\_\_\_

WITNESS

1903 South 6th St, Suite 4  
Brainerd, MN 56401

119 NE. 1st Street, Suite 6  
Little Falls, MN 56345

3201 Pine Ridge Ave. NW, Suite B  
Bemidji, MN 56601

1225 Washington Ave.  
Detroit Lakes, MN 56501

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E-mail us at: [referrals@omsamn.com](mailto:referrals@omsamn.com)