Medical Record Release

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, medical information bureau, or other organization, institution, or person, that has any records or knowledge of my health, to give to O'Leigh Aesthetic Surgery Center, LLC, any such information if so requested.

A photographic copy of this authorization shall be as valid as the original.

Signature ____________________________________ Date ________________________