



Medical Information Records Release

Date: _____

I, _____ hereby authorize the release
of my medical records in your possession to be forwarded to:

Windy Olaya, MD.

1310 W. Stewart Drive STE 511

Orange, CA 92868

Fax (855) 230-1459

Patient's Name:

Date of Birth:

Patient's Signature:

Please specify information requested:

Windy Olaya, MD
P: 714-504-9225 F: 855-230-1459
1310 W. Stewart Drive #511, Orange, Ca 92868
www.PINKsurgery.com