

**PATIENT AUTHORIZATION FOR RELEASE OF RECORDS**

I AUTHORIZE AND CONSENT TO \_\_\_\_\_ OBTAINING COPIES OF MY MEDICAL AND DENTAL RECORDS FROM MY CURRENT OR PREVIOUS PHYSICIANS, DENTISTS, PSYCHOLOGISTS, AND HOSPITALS, OR ANY OTHER MEDICAL/DENTAL PROVIDER. I EXPRESSLY AUTHORIZE ANY OF THE FOREGOING MEDICAL CARE PROVIDERS OR ENTITIES TO RELEASE COPIES OF MY RECORDS TO \_\_\_\_\_, AND TO DISCUSS WITH \_\_\_\_\_ THE CARE AND TREATMENT RENDERED TO ME. THIS AUTHORIZATION AND CONSENT SHALL BE VALID UNTIL WITHDRAWN BY ME, IN WRITING.

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(PATIENT OR LEGAL GUARDIAN)