

I hereby authorize and give consent to my dentist to obtain copies of my medical and dental records from current or past dentists, physicians, psychologists or hospitals and I hereby expressly authorize any dentist, physician, psychologist, hospital, or any other medical/dental care provider to release copies of my records to my dentist upon request. I also authorize any health care provider who has treated me to discuss my care and treatment with my dentist. This authorization shall be valid until withdrawn by me, in writing.

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Patient Signature