**PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS**

 **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 I hereby authorize the release any and all of my medical records to Comprehensive

Spine Care, P.A. if requested for the purpose of continued care, insurance, legal or personal reasons.

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken)

 by written, dated and signed communication.

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_