



**GENERAL PATIENT RECORDS RELEASE AUTHORIZATION**

PATIENT NAME: \_\_\_\_\_

I authorize the release of all records and/or consent to communication between \_\_\_\_\_ and Hudson Orthodontics for treatment-related reasons.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature of patient or parent/guardian

\_\_\_\_\_  
Date