Consent Form to Release Health Information

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____ Patient date of birth ____ /____ / _________

Patient First name Middle name Last name MM DD YYYY

____

Patient Home address City State Zip Code

____

Patient phone Home Cell Work

Previous name(s) ______________________________

I, __________________________ **authorize** the release of:

_____ **all** information OR _____diagnosis, treatment recommendations, treatment progress
_____ orthodontic records
_____ appointments
_____ financial & insurance information
_____ other information (please specify) ________________________________

This information may be released to:

Name (Printed)	Name (Printed)	Name (Printed)
Address	Address	Address
City State Zip Code	City State Zip Code	City State Zip Code
Phone	Phone	Phone
Relationship	Relationship	Relationship

If any third party is making a payment for a patient, our office will discuss financial arrangements and what they are paying for.

This "release of information" will remain in effect until terminated by me in writing.

______________________________ ______________

Signature Date

____

Printed name