Associated Orthodontists EST. 1969

Patient Release of Information Authorization

I _________________________ give permission for person/persons listed below
(Parent/Guardian/Patient)

to obtain information from Associated Orthodontists, Ltd. for any purpose including but not limited to, financial, healthcare, insurance, website, and/or treatment until revoked in written authorization.

Patient Name:

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Name of Person Authorized to Receive Information   Relationship to Patient

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Name of Person Authorized to Receive Information   Relationship to Patient

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Signature of Parent/Guardian/Patient   Print Name   Date