Associated Orthodontists EST. 1969

CONSENT TO COMMUNICATE TO OTHERS

PLEASE USE THIS FORM TO AUTHORIZE ASSOCIATED ORTHODONTISTS TO RELEASE HEALTH INFORMATION TO THE PERSON OF YOUR CHOICE — OTHER THAN PARENT/LEGAL GUARADIAN OR RESPONSIBLE PARTY.

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: ____

____

Name of Person Authorized to Receive Information Relationship to Patient

____

Phone

____

Name of Person Authorized to Receive Information Relationship to Patient

____

Phone

____

Signature of Parent/Legal Guardian/Patient Print Name Date