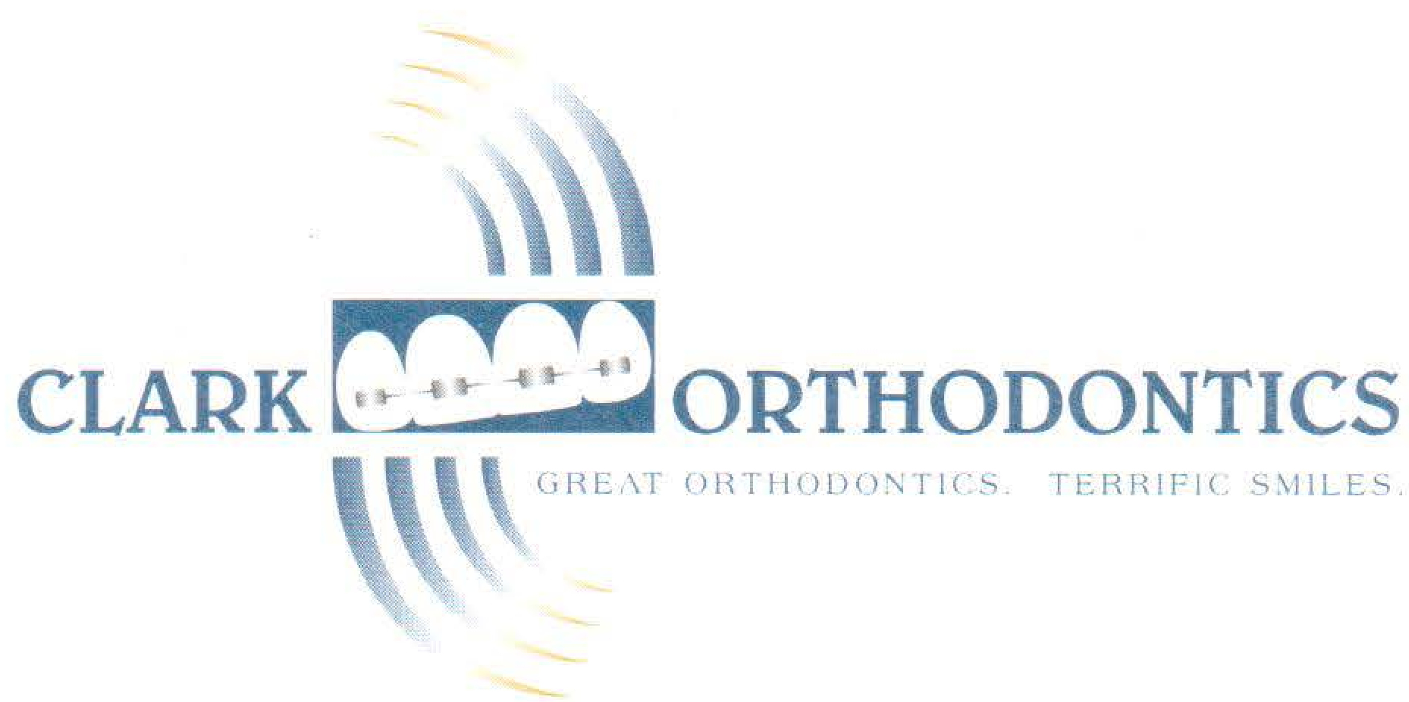

Clark Orthodontics:

Authorization to Disclose Information For: ______________________________

I ______________________________ give my consent for Clark Orthodontics to release dental and billing information to the following person(s):

Name ____________________________ Relationship ____________________________

Name ____________________________ Relationship ____________________________

Name ____________________________ Relationship ____________________________

Name ____________________________ Relationship ____________________________

Name ____________________________ Relationship ____________________________

May we leave a message on cell phone? Yes____ No _____ Cell # __________________

May we leave a message on your phone home number? Yes______ No ______
Home # ____________

I also understand that it is my responsibility to notify Clark Orthodontics of any changes in authorization.

This authorization is valid indefinitely unless we receive written notification of any changes.

____ ________________________

Patient, Parent, or Legal Guardian **Date**

____

Printed Name of Patient, Parent, or Guardian

____

Signature of Witness from Clark Orthodontics

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Shelbyville, Indiana 46176
317) 392- 6166
Facsimile 317 392-6196
www.smilesbyclarkortho.com

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