

Grafton Orthodontics, S.C.
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**AUTHORIZATION TO RELEASE OR DISCLOSE HEALTH
INFORMATION**

Name:

Date of Birth:

I request and authorize the above listed doctor and practice to release my protected health information to the family members and others listed below for the purpose of communicating results, findings, and care decisions including financial and insurance matters.

Name: _____

Name: _____

Name: _____

Name: _____

This request and authorization applies to health care information related to examinations or treatment performed at Grafton Orthodontics, S.C. in Grafton, Wisconsin.

I understand I can cancel this agreement by sending the above office a letter revoking this authorization.

Signature of Patient or Representative

Date