Grafton Orthodontics, S.C.

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(262) 377-8950

AUTHORIZATION TO RELEASE OR DISCLOSE HEALTH INFORMATION

Name of Patient:_____

Date of Birth:_____

I request and authorize Grafton Orthodontics 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_____**Relationship**_____

Name_____**Relationship**_____

Name_____**Relationship**_____

Name_____**Relationship**_____

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.

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Signature of Patient or Representative Date