American Association of Orthodontists

Request for Release of Records

Date: _____

I (Patient's Name) _____ hereby request and give my permission to

Dr. _____ to provide

Dr. _____

Address _____ City _____

State/Province _____ Zip Code _____

any and all information which he/she may request with respect to the orthodontic care of (Patient) _____

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models and copies of all dental records and medical records.

I agree to pay the cost of duplicating any records. A photocopy of this release will be as effective and valid as the original.

Signed _____ Date Signed _____
(Patient)

Social Security # _____

Phone _____

Address _____ City _____

State/Province _____ Zip Code _____

Signed _____ Date Signed _____
(Parent, Legal Guardian or Custodian of the Patient, if appropriate)

Print Name _____

Phone _____

Address _____ City _____

State/Province _____ Zip Code _____

Reviewed 2018