AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS FORM IS OPTIONAL *(COMPLETE ONLY IF FISHBEIN ORTHODONTICS MAY SHARE PATIENT INFORMATION WITH OTHERS SUCH AS* ***STEPPARENTS, GRANDPARENTS, SPOUSE, FRIENDS,*** *ETC.)*

Patient Last Name _____ First Name_____

Patient's Date of Birth ___/___/_____ Address_____

I, (Name of Patient or Legal Guardian if patient is under 18 years of age) _____, hereby authorize Fishbein Orthodontics to release information, as indicated below, to the following person(s) listed below.

Check the Information to Release:

Name	Relationship	Phone #	Any	Clinical	Financial

I authorize Fishbein Orthodontics to contact the individual(s) listed above to convey information as listed above regarding the 'patient' in the event that I am unable to be reached by Fishbein Orthodontics.

I understand that I may revoke/cancel this authorization by notifying Fishbein Orthodontics, in writing, of my intent to revoke authorization, or change the name(s) of those listed to whom the information is to be released.

Please note that if the patient is under the age of 18, a Legal Guardian must either be present during the Initial Consultation, or must have this page filled out with the name of the individual(s) bringing the patient to the Exam.

_____ _____

Signature of Patient
OR Legal Guardian if Patient is under 18 years of age

Date

fishbein ORTHODONTICS