**Consent to Release/Request Orthodontic Records**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby request and give permission to Zwanziger &

***(Parent, Guardian, or Patient)***

Boe Orthodontics to provide:

***Office to Receive Records:***

***Address:***

***City, State, 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, radiographs, 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.

**Signature of Parent, Guardian, or Patient:** ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name of Parent, Guardian, or Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information:**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_