CASTLE HILLS
3D ORTHODONTICS
Smile with Style

# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS FORM IS OPTIONAL (COMPLETE ONLY IF CASTLE HILLS 3D 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 Castle Hills 3D Orthodontics to release information to the following person(s) listed below.

**Check the Information to Release:**

| Name | Relationship | Phone # | Any | Clinical | Financial |
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I authorize Castle Hills 3D 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 Castle Hills 3D Orthodontics.

I understand that I may revoke/cancel this authorization by notifying Castle Hills 3D 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