

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: _____