Name of Patient: _____ Date of Birth: _____

Midwest Orthodontic Associates is authorized to release protected health information about the above-named patient to the parties named below.

Description of information to be released

Treatment information and recommendations

Results of tests / x-rays

Appointment reminders and history

Financial information: description of service, fee, payment plan, balance

Insurance information including description of service, fee, benefits paid, balance

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Signature of Patient or Responsible Party Date