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.

Person to receive information	**Description of information to be released** Please draw a line through any information that you do not want released to the person on the left.
Spouse (provide name & phone number)	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
Parent (provide name & phone number)	Treatment information and recommendations Results of tests / x-rays Appointment reminders and history Financial information including description of service, fee, payment plan, balance Insurance information including description of service, fee, benefits paid, balance
Other (provide name, relationship & phone number)	Treatment information and recommendations Results of tests / x-rays Appointment reminders and history Financial information including description of service, fee, payment plan, balance Insurance information including description of service, fee, benefits paid, balance
Other (provide name, relationship & phone number)	Treatment information and recommendations Results of tests / x-rays Appointment reminders and history Financial information including description of service, fee, payment plan, balance Insurance information including description of service, fee, benefits paid, balance

_____ _____

Signature of Patient or Responsible Party Date