DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

BAUMWOLL ORTHODONTICS

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NJ Specialty License #6008

Member American Association of Orthodontists

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PATIENT INFORMATION
Baumwoll Orthodontics

I, _____, **(Patient, Parent or Guardian)** voluntarily consent and authorize the healthcare provider named above to use or disclose health information related to _____,(**Patient Name)** throughout the course of treatment, to the individual(s) I identify below.

If anyone other than the parent, legal guardian, or patient will be accompanying the patient into the office, please list their name(s) below and **CIRCLE** the specific information we are permitted to share with them.
Important: Spouses are not automatically granted access. If you wish for us to share treatment details with them, their names must be included below.

Please note: No information will be disclosed, and access to treatment areas will not be permitted without prior written consent from the legal guardian.

Appointments **Financial** **Dental** **Treatment** **Insurance** **Other**

Name of Authorized person:_____ Relationship:_____

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Patient Signature:_____Date:_____
Guardian/Parent Signature if under 18:_____
Date:_____