American Association of Orthodontists®

My Life. My Smile. My Orthodontist.®

Request for Release of Records

Date: ______________________

I (Patient's Name) ___________________________________hereby request and give my permission to

Dr. ________________________________to provide Dr. ______________________________________

Address ____ City ____________________________

State/Province ______________________________ 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, x-rays, 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.

Signed ____ Date Signed _________________

(Patient)

Social Security # _______ -_________- ________

Phone ________________________________

Address ____ City ____________________________

State/Province _____________________________Zip Code ___________________

Signed ____ Date Signed ___________

(Parent, Legal Guardian or Custodian of the Patient, if appropriate)

Phone _______________________

Address ____ City ____________________________

State/Province _____________________________Zip Code ___________________

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