Additional Authorized Party Form

Please list any authorized individuals who you give permission to request information and/or schedule appointments for the patient. *Please be sure to list all parents* and *anyone who will be bringing patient for appointments or calling to schedule appointments.*

Patient Name ____ Age _____________

Name ____

Address ____

City ______________________________________ State _____________ Zip____________

Relationship to patient ____

Phone number ____

Date of Birth ____ (for verifying purposes only)

Name ____

Address ____

City ______________________________________ State _____________ Zip____________

Relationship to patient ____

Phone number ____

Date of Birth ____ (for verifying purposes only)

Name ____

Address ____

City ______________________________________ State _____________ Zip____________

Relationship to patient ____

Phone number ____

Date of Birth ____ (for verifying purposes only)

I authorize Mancini Orthodontics to release information regarding the listed patient to the people I've provided above. I give my permission for them to schedule appointments and receive updates (as they request) on patient treatment/care.

Printed Name ____ Date _____________________

Signature ____ Date _____________________