Authorized Party Form

Please note: Mother and Father are automatically authorized unless formal documents state otherwise. Please include a copy of the document(s) with your paperwork.

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 or receive updates on treatment.*

Patient Name _____ Age _____

Patient's Mother:_____ Contact #_____ DOB: _____

Patient's Father: _____ Contact # _____ DOB: _____

Additional Authorized Party (ex: Grandparents, stepparents etc.)

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 give permission to Mancini Orthodontics to release information regarding the listed patient to the people I have 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 _____