Additional Authorized Party Form

Please list any additional authorized individuals who you give permission to receive information and/or schedule appointments for the patient. The patient's mother and father are automatically authorized. *Please be sure to list anyone who will be bringing patient for appointments or calling to schedule appointments or receive updates on treatment.*

Patient Name _____ Age _____

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

Name _____

Address _____

Relationship to patient _____

Phone number _____

Date of Birth _____ (for verifying purposes only)

Name _____

Address _____

Relationship to patient _____

Phone number _____

Date of Birth _____ (for verifying purposes only)

Name _____

Address _____

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 _____