Rosenthall Orthodontics
The center of your smile.

Authorization to Release Orthodontic Needs

Rosenthall Orthodontics is dedicated to our patients. Our goal is to give our patients the best possible treatment with the least inconvenience, using the most advanced treatment techniques and materials. We strive to exceed our patient's expectations in every aspect of their orthodontic treatment.

Patient's Name _____ Date of Birth _____

It is the policy of our office not to release patient information about you or your child unless it is for patient care and treatment or payment. Our office is an open bay concept. We try, to the best of our ability, to keep the discussion of patient information to a minimum. If you wish for Dr. Rosenthall and/or office staff to leave messages for you on your home telephone, message number, answering machine, work telephone, voice mail, cell phone or pager, or to any other person, then you must sign the following:

I authorize Mark R. Rosenthall, DDS, MSD or staff to release patient information about me/my child and agree it is my responsibility to notify the staff whenever I want this to change.

Patient/Guardian Signature _____ Date _____

Witness _____ Date _____

You may also disclose information to my family members and non-family members listed by name and relationship.

NAME RELATIONSHIP

_____

_____

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