CONSENT TO REQUEST/RELEASE DENTAL/ORTHODONTIC RECORDS AND INSURANCE INFORMATION

I do hereby consent and authorize:

1) ____ to release to
(Dentist/Orthodontist Name/Office)

   Valley Orthodontics information in my/my child's record including current and previous dental/orthodontic records from other practitioners which are part of my/my child's record.

2) Valley Orthodontics to request information from my insurance company and other providers.

3) Valley Orthodontics to release dental/orthodontic records in the event that information is needed by other dental specialists or my insurance company.

Patient Name: ____

Patient/Guardian signature: ____

Print: ____

Relationship to patient: ____

Date: ____

(We prefer that digital records are sent in a digital format via email whenever possible.)

Please send records to:

Valley Orthodontics
2400 Las Gallinas Avenue, Suite 130
San Rafael, CA 94903
Phone: 415-479-2400
FAX: 415-901-2628
Email: smiles@valleyorthodontics.net