floyd family orthodontics

Patient Name: _____ DOB: _____

Associated Family Members: _____

I, _____, request and authorize _____ to release health care information of the patient (s) above. Please provide it to:

Floyd Family Orthodontics
863 West Main Street, Suite 200
Molalla, OR 97038
Email: contactus@floydfamilyortho.com

Questions? Phone 503-878-8887

____ Pano

____ Ceph

____ CT Scan

____ Medical Diagnosis/ Information

I understand I have the right to revoke this authorization at any time by writing to Floyd Family Orthodontics.

_____ _____
Signature of Individual or legal representative Date

_____
Relationship to Patient (s)