Nancy A. Casey, D.M.D.

ORTHODONTIC ASSOCIATES
55 York Road
Warminster, PA 18974

215-674-0332

Fax 215-674-9722
www.casey4braces.com
info@casey4braces.com

AUTHORIZATION TO RELEASE MEDICAL/DENTAL INFORMATION

Patient name _____ DOB _____

Referred by _____

I authorize to release my medical/dental records to:

My family **physician**_____

Group name _____Location_____

My family **dentist** _____

Group name _____ Location_____

I authorize to release my medical/dental records to all medical/dental sources, including any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf.

Patient/Guardian signature _____ Date _____

FINANCIAL/RESPONSIBLE PARTY

□ Self □ Parent □ Guardian □ Spouse □ Other _____

Name _____

Address_____

_____

Phone _____

Date of Birth _____

Orthodontic Insurance Coverage

Company_____

ID# _____