MEDICAL INFORMATION RELEASE FORM

Patient Name(s) _____

I authorize the release of all medical information, including records and insurance claims, to the following (please mark all that apply).

☐ Name: _____

Circle Relation to Patient: mother/father/step mother/step father

☐ Other (e.g. aunt, grandparent, legal guardian): Name: _____

Relation to patient_____

☐ Treating Orthodontist or other coordinating Health Care Professionals

☐ Information is not to be released to anyone other than myself

I **DO NOT** authorize this information to be disclosed in the following ways (please mark all that apply).

☐ Verbal ☐ Fax ☐ Electronic Mail ☐ Text

Messages: I give authorization to be reached by the office and Lighthouse (our automated patient communication system) through the following options (please update and mark all that apply):

☐ home _____
☐ work _____
☐ cell _____
☐ e-mail _____
☐ text _____

If unable to reach me:

☐ you may leave a detailed voice message
☐ you may leave a message with my spouse
☐ please leave a message asking me to return your call
☐ Other_____

This *Release of Information* will remain in effect until terminated by me in writing, and I release Dr. Jennifer K Hargleroad DDS, MS from any and all state or federal statutes relating to patient privacy.

Print Name _____ Relation to Patient _____

Signature _____ Date _____

NON LEGAL GUARDIAN PATIENT ESCORT FORM

A legal guardian who wishes to have their child be accompanied by a person other than a legal guardian, please complete the section below.

Patient Name(s) _____

I, _____, the parent/legal guardian authorize my child to be escorted to his/her dental appointment by_____. I authorize this person to provide consent for any proposed dental treatment and to provide updated medical history information for my child. I also authorize this person to receive financial information regarding my account.

I authorize Jennifer K. Hargleroad DDS MS PLLC to examine, take radiographs, perform dental cleaning and apply fluoride. I also authorize the doctor to perform any proposed dental treatment including, but not limited to, stainless steel crowns, fillings, extractions, and the administration of local anesthesia and nitrous oxide. I also authorize any necessary treatment in the event of a medical emergency.

Escort Name_____

Relationship to Patient_____

Phone number of parent/legal guardian_____
***Please be available by phone during the appointment

Signature of parent/legal guardian_____

Printed Name of parent/legal guardian_____

Date of signature_____

Office Use Only: