Patient Consent to Share Protected Health Information

This form will allow us to leave a message on the voicemail of the numbers provided or to share the patient's health information with individuals involved in the patient's health care. I understand information may also be communicated via: fax, photocopy, verbal communication, and/or direct mail.

PATIENT INFORMATION:

Name of patient: ____

Date of birth: ____

Social Security number: XXX-XX-________________________(last 4 digits only)

Phone number: ____

Other number: ____

I (the undersigned) hereby consent to J. Orthodontics, Inc. leaving a voicemail message at the numbers indicated above and/or discussing with the individual(s) listed below, information related to my or my child's orthodontic treatment. These communications may include, but are not limited to, appointment reminders, medications, registration, billing and insurance items, and any information pertaining to orthodontic treatment.

With my consent, J. Orthodontics, Inc. may discuss my or my child's care with the following individuals.

Name:	**Relation to patient:**

If certain information is NOT to be included, please list:

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