

J. Orthodontics Inc.

YOUR RIGHTS WITH RESPECT TO THIS CONSENT:

I understand that I have the right to revoke this consent at any time, by sending a written statement to J. Orthodontics, except to the extent J. Orthodontics has already made a disclosure in reliance upon my prior consent. Unless revoked, this consent is valid until the expiration date listed below. A photocopy of a signed consent is acceptable, provided that it is apparent that the consent was signed and dated prior to photocopying.

I further understand that this consent does not permit the release of my actual medical records to the individual(s) listed above. Such release will only be made if I sign a separate valid authorization.

If I fail to specify an expiration date, event or condition, this consent will be valid for one year.
Expiration Date / Event / Condition:

Signature of Patient or Legal Representative

Date

(If signed by Legal Representative, state relationship and authority to do so)

Patient is: Minor Incompetent Disabled Deceased

Legal Authority: Custodial Parent Legal Guardian

Executor of Estate of Deceased Authorized Legal Representative

Signature of Witness

Date

Office Use only:

Received by: _____

Date: _____