WESTLAKE FAMILY ORTHODONTICS

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Authorization for Use and Disclosure of Protected Health Information

_____ I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the below-named patient. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

_____ I give Westlake Family Orthodontics, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, scheduling, insurance, or payment.

_____ I authorize use of this form on all my insurance submissions, and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Westlake Family Orthodontics to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Westlake Family Orthodontics, and I permit a copy of this authorization to be used in place of the original. I grant the right to Westlake Family Orthodontics to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

RECORDS RELEASE

- Please list any other parties (parent, stepparents, guardian, spouse, or other family) to whom we may provide protected information:

Name: _____ Relationship to Patient: _____

Select all that apply: ☐ Treatment-related information ☐ Insurance-related information

PHOTO CONSENT

Westlake Family Orthodontics on occasion takes photos and videos of patients to be used in the office, on the website, other social media, and related publications. This list is not inclusive but serves to demonstrate situations in which patients might be photographed, (please initial one)

_____ Yes, I give permission to WFO to display photo(s) or video(s) of the patient in association with WFO events, functions, or publications.

_____ No, I request that photo(s) or video(s) of the patient NOT be displayed in association with WFO events, functions or publications.

_____ _____
Signature of Patient or Legal Guardian Regarding Patient(s)

_____ _____
Relationship to Patient Date