Patient Information Release

ANDERSON ORTHODONTICS
Anissa Monseau Anderson, DDS, MS

Patient: _____ **Date:** _____/_____/_____
First Middle Last

Birth date: _____/_____/_____

Maintaining the privacy of our patients' information is important to Dr. Anderson and the office personnel. Such information is stored in secure and password-protected areas and can be released only with written permission from the responsible party(s).

Patient information *(appointment date/time, appointment arrival-departure confirmation, treatment plan/progress, payment plan, account balance)* will **NOT** be released to an unauthorized person(s).

Please list below the person(s) authorized (non-custodial parents, step-parents, grandparents, guardians, etc.) to receive information concerning the patient named above.

☐ Appointment (scheduling)
☐ Treatment (progress)
☐ Financial (payments)

Name: _____
Address: _____
Phone: (____)_____ (____)_____
Relationship to patient: _____

☐ Appointment (scheduling)
☐ Treatment (progress)
☐ Financial (payments)

Name: _____
Address: _____
Phone: (____)_____ (____)_____
Relationship to patient: _____

☐ Appointment (scheduling)
☐ Treatment (progress)
☐ Financial (payments)

Name: _____
Address: _____
Phone: (____)_____ (____)_____
Relationship to patient: _____

I,_____, the patient or parent/guardian of the above listed patient, hereby permit the above listed person(s) to receive the information as specified above. I understand that I am responsible to update (add or remove names) this form as needed. I understand that listing a person above does not change or share financial responsibility for the patient's account.

_____ _____
Signature of Patient/Parent/Guardian Date

OFFICE USE
Updated ___/___/_____ **Initials** _____
Updated ___/___/_____ **Initials** _____

Anissa M. Anderson, DDS, MS ♦ *Specialist in Orthodontics*
80 McEldowney Avenue ♦ 304.455.4200
New Martinsville, WV 26155 ♦ wvandersonortho.com