JOLLEY SMILES
ORTHODONTICS

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PERMISSION TO ACCESS RECORDS

Patient Name: _____

Your Name: _____

Relationship to Patient: _____

I give the following list of people permission to access the records for the above listed patient:

NAME TO GRANT PERMISSION	HEALTH	FINANCIAL	TREATMENT NOTES

☐ **I DO NOT wish to grant anyone access to the above patients records.**

Signature of Patient or Guardian: _____ Date: _____

Signature of Treatment Coordinator: _____ Date: _____