Dental Specialties of Saint Louis University
Orthodontic Clinic

SHARING HEALTH/FINANCIAL INFORMATION

(Print name of patient) (Birth date) (Patient ID#)

(Street address) (City, state, zip code)

(Primary contact phone number) (Patient phone number) (Primary contact email address)

I permit Dental Specialties of Saint Louis University-Orthodontic Clinic, their faculty, residents, dental assistants, and other personnel ("Orthodontic Care Providers") to discuss health and related financial information, in person or by telephone, with the following family members or friends involved in my dental care. This authorization is limited to communications regarding orthodontic treatment and related condition(s). **Place an X next to your first choice of communication.**

Identify below family members or others involved in your care or payment that we may share information with:

Name	**Relationship**