



AUTHORIZATION FOR RELEASE OF ORTHODONTIC RECORDS

Transfer to:

Transfer from:

Arkansas Orthodontics
3533 North Shiloh Dr.
Suite 3
Fayetteville, AR 72703
(479) 442-3411

Arkansas Orthodontics
4400 Rogers Avenue
Suite C
Fort Smith, AR 72903
(479) 782-7080

Arkansas Orthodontics
1400 S.E. Walton Blvd.
Suite 42
Bentonville, AR 72712
(479) 271-9944

THIS is to authorize the release, mailing and transfer of my complete orthodontic patient file, including any and all information and documents in your possession or under your control regarding my treatment and condition, as well as financial records, or that of my child, as reflected by the signature block below, to a representative of **ARKANSAS ORTHODONTICS OR** _____

_____ bearing this authorization, with original signature, who has been instructed to deliver it to the above identified office or individual.

IN ADDITION, you are authorized to discuss with any of the **ARKANSAS ORTHODONTIC OR** _____

associates or staff, any aspect of my care, including, but not limited to examination, diagnosis, treatment, prognosis and financial arrangements.

FOR THIS specific request, this authorization is valid without limitation as to time.

Patient's Name

Signature: Patient, Parent, Legal Guardian

Dated: _____

3533 N. Shiloh Drive Suite 3 Fayetteville, AR 72703 (479) 442-3411	4400 Rogers Avenue Suite C Fort Smith, AR 72903 (479) 782-7080	1400 S.E. Walton Boulevard Suite 42 Bentonville, AR 72712 (479) 271-9944
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