Kerzner Orthodontics, P.C. Personal Health/Financial Disclosures

Patient Name *(please print)*

Signature of Patient or Parent/Guardian if under 18

Date

I, _____, do hereby grant permission for Kerzner Orthodontics, P.C., to
Patient or Parent/Guardian if under 18 *(please print)*

disclose any personal health information and/or personal financial/billing information regarding the listed patient below to the following personal representative(s): (spouse, sibling, parent, grandparent, child, friend, etc.)

Please list full names below:

PERSONAL HEALTH INFORMATION	PERSONAL FINANCIAL INFORMATION

I understand that this permission will remain in effect unless a written cancellation has been provided to Kerzner Orthodontics, P.C.

☐ I, _____, do **NOT** grant permission for any and all personal **financial and billing information** to be shared with any personal representative(s).
Patient or Parent/Guardian if under 18 *(please print)*

☐ I, _____, do **NOT** grant permission for any and all personal **health** information to be shared with any personal representative(s).
Patient or Parent/Guardian if under 18 *(please print)*