RELEASE OF MEDICAL INFORMATION FOR PURPOSES OF CONSULTATION

Patient Name: _______________________________________

I ________________________________, by my signature below consent to the release of my/ my child's medical information for the purposes of obtaining a consultation and hereby consent to the following:

1. I understand that orthodontic practice is not an exact science and that there may exist various interpretations of, approaches to, and means for correcting a given orthodontic problem.

2. It is natural and expected, that at certain times, health care providers, including orthodontists, will consult with one another about certain diagnostic aspects and treatment alternatives concerning one of their patients.

3. I understand that my dentist may consult with other health care providers concerning certain aspects of my treatment and I encourage him/her to do so for my benefit whenever the need arises.

4. I understand that if my dentist undertakes to consult with other health care providers concerning my diagnosis and/or treatment, my medical records may be evaluated by other health care practitioners. Therefore, I fully consent to the release of any medical information contained therein for this purpose.

5. If my dentist consults with other doctors about my diagnosis or treatment, it is my understanding that:
    a. Any recommendations made to my dentist may or may not be followed, as my dentist sees fit.
    b. I may or may not consult with any of the consultants,
    c. I may or may not ever meet any of the consultants,
    d. I do not have an expectation of having a doctor-patient professional relationship with any consultant whom I do not meet.
    e. I do not expect to be billed by any consultant with whom I do not meet.

6. If my dentist does consult with other health care providers for my benefit:
    a. I expect him/her to use his /her best professional judgment in evaluating the consultant's recommendations,
    b. I expect him/her to use whatever information or input he/she receives in my best interest
    c. I expect the ultimate diagnostic and treatment recommendations to rest with my dentist and not with the consultant, and
    d. All decisions regarding accepting or rejecting treatment recommendations made by my dentist rests with me.

7. If English is not my primary language, I have had the opportunity to have this interpreted for me and I fully understand the words and concepts expressed herein.

8. I have had the benefit and the opportunity to ask and have answered any questions pertaining to this release.

_____________________________ ____________________

Signature of Patient or Parent Date