Brodie L. Bowman, DMD

Specialist in Orthodontics & Dentofacial Orthopedics

C H I L D R E N + T E E N S + A D U L T S

AUTHORIZATION TO RELEASE / DISCUSS INFORMATION

I, ________________________________, being of legal age, give Dr. Brodie L. Bowman authorization to release and discuss health, dental, and financial information regarding ________________________________ with the person / persons listed below:

Name:________________________________Relationship to patient:______________________

Home#:____________________Mobile#:____________________Work#: ____________________

Name:________________________________Relationship to patient:______________________

Home#:____________________Mobile#:____________________Work#: ____________________

Name:________________________________Relationship to patient:______________________

Home#:____________________Mobile#:____________________Work#: ____________________

Name:________________________________Relationship to patient:______________________

Home#:____________________Mobile#:____________________Work#: ____________________

This authorization will stay in effect unless I request that it be changed.

Print Name:____

Signature ________________________________ Date________________________________