Dr. Jennifer Meader
16006 Ash Way Ste. 102
Lynnwood, WA 98087
PH: 425-774-1124

Patient Name____________________________

Consent to Undergo Orthodontic Treatment

I hereby consent to the making of diagnostic records, including x-rays photographs and impressions for models, before, during and following orthodontic consultation. I fully understand all of the risks associated with the treatment.

Authorization for Release of Patient Information

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information.

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Signature of Patient/Parent/ Guardian Date

____

Witness Date

I have the legal authority to sign this on behalf of

____

Name of Patient

____

Relationship to Patient