R. SCOTT SCHALO D.D.S., M.S.
PERSONALIZED ORTHODONTICS

DIAGNOSTIC RECORDS CONSENT

Patient:_____ Date:_____

I, _____, herby authorize R. Scott Schalo, D.D.S., MS and/or employees, to take whatever x-rays deem necessary for the orthodontic care of _____.

(PATIENT)

I also give my consent for the office of R. Scott Schalo, D.D.S. M.S., to release and/or receive any and all dental records to or from the patients: General Dentist, Oral Surgeon, Periodontist, Insurance Companies or any other person or entities that may be deemed necessary for the continuing care of the patient.

I agree that the dental practice may communicate with me electronically at my personal email address listed: _____@_____. I also understand I can withdraw my consent by calling Dr. Schalo's office at 530-223-0460.

By signing this form I am releasing and agree to hold harmless R. Scott Schalo, D.D.S., MS and/or employees from any and all responsibility and liability that may arise from complying with this authorization and consent to release my dental records.

This consent is valid during the entire course of treatment or until a written withdrawal of consent is submitted.

I acknowledge the receipt of a signed copy of this authorization and consent form.

_____

Signature of Patient or Authorized Representative (Relationship) Date

Member American Association of Orthodontists

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