LAKESHORE ORTHODONTICS
JASON L. CHARNLEY, D.D.S., M.S.

Patients Name:____

Date of Birth:_______________________

I HEARBY AUTHORIZE LAKESHORE ORTHODONTICS, PLC. TO SHARE:

☐ Any of my medical/dental information, including information about:

  ☐ Including diagnosis and treatment

  ☐ Including financial information

WITH THE FOLLOWING PEOPLE:

Full Name:____________________________________Relationship:____________________

Full Name:____________________________________Relationship:____________________

Full Name:____________________________________Relationship:____________________

Full Name:____________________________________Relationship:____________________

Signature_____________________________________Date_____________________________

Relationship to minor patient (if parent or legal guardian)____________________________