GALLETTO & ASSOCIATES
ORTHODONTICS

Date: ________________

Patient First & Last Name: ________________________

Other Family Members in Treatment: ________________

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In this busy world we live in, we understand that it may become necessary for you to use other family members or friends to bring your child(ren) to orthodontic appointments.

For HIPAA Compliance, it is necessary for us to establish a list of persons **who have** permission to discuss your child(ren)'s concerns with us. Please fill in the information below:

NAME	RELATIONSHIP TO PATIENT

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Parent/Guardian/Patient Signature

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