

Authorization Form

I authorize Reuland Orthodontics to take facial and oral photographs, panoramic x-ray and cephalometric head x-ray of my self/child, for the benefit of a more thorough examination.

I also understand that there will be no charge for these records; however a \$200.00 fee will be required for these records to be removed from our office.

Patient's Name

Date of Birth

Signature (Parent's Signature if minor)

Date