7695 Cardinal Court, Suite 320, San Diego, CA 92123
T 858.277.8080 F 858.277.8090
www.DrEhsani.com

AUTHORIZATION FOR RELEASE OF ORTHODONTIC RECORDS

❑**Transfer to:** ❑**Transfer from:**

This is to authorize the release, mailing and transfer of my complete orthodontic patient file, including any and all information and documents in your possession or under your control regarding my treatment and condition, as well as financialrecords, or that of my child, as reflected by the signature block below, to a representative of **NADER EHSANI, DDS,INC. OR**_____ bearing this authorization, with original signature, who has been instructed to deliver it to the above identified office or individual. IN ADDITION, you are authorized to discuss with any of the **NADER EHSANI, DDS, INC. OR** _____associates or staff, any aspect of my care, including, but not limited to examination, diagnosis, treatment, prognosis and financial arrangements. FOR THIS specific request, this authorization is valid without limitation as to time.

Signature: _____

Patient, Parent, Legal Guardian's Name: _____

Dated: _____