ORBIT
ADVANCED IMAGING
FOR TEETH, FACE, JAWS & AIRWAY

AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS

Requested by: Patient

I, ____ residing at

Patient's Legal Name / Patient and Guardian's Legal name (for minors)

____

Street Address City Province Postal Code

hereby request and authorize ORBIT ADVANCED IMAGING to disclose and release copies of any diagnostic records and information concerning my care to:

____

Receiving entity (Doctor / Laboratory / Patient / Guardian's name)

____

Street Address City Province Postal Code

Email: _______________________________________ Phone number: ______________________

Receiving entity Receiving entity

These records include, but are not limited to: patient personal information, radiographs, scans, photographs, diagnostic models, reports and other related materials.

I release from any liability and accountability Orbit Advanced Imaging from any and all obligation proceeding from compliance with this request and the disclosure of the requested information.

Signed by: ______________________________________ Date: _____________________________

Patient or Guardian's Signature

FOR OFFICE USE ONLY

Proof of photo identification presented: ____

Identification ID number

____

Identification ID number

Verified by: ___________________________________ Signature: ____________________________

Date: ___________________________________