ADVANCED IMAGING
FOR FACE, TEETH, JAWS & AIRWAY

AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS

Requested by: Doctor

I, ______________________________ , ____________________
Referring Doctor's Name — College License Number

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

Patient Name: ______________________________

Address: ______________________________

Birthday: ____________________ Age: __________ Gender: __________

To: ______________________________
Receiving Entity (Parent/Guardian Name / Doctor's Name / Laboratory)

Email: ______________________________
Receiving Entity

Phone number: ______________________________
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: ____________________
Referring Doctor's Signature