**FORM B**

MASSACHUSETTS GENERAL HOSPITAL
IMAGING

**3D Imaging Service**
**55 Fruit Street - Gray 267C**
**Boston, MA 02114**
**Telephone: (617) 724-3667**
**Fax: (617) 643-2992**

## Authorization for Release of CT Dental Images

**Patient Name**: _____
(print please)

**Date of Birth:** _____

**Medical Record #**: _____-

I hereby authorize Massachusetts General Hospital to furnish medical images from my image file.

**NEW DENTISTS'S NAME:** _____
**DENTIST'S TELEPHONE#:** _____

**MAIL TO (*Check one*)** ☐ **PATIENT OR** ☐ **NEW DENTIST**

**MAILING ADDRESS:** _____
_____
_____

**Date of Study:** _____

**Simplant Version (Simplant Pro or Version 7 above)** _____

**Media Type: (CD or DICOM CD or Prints)** _____

**Please call Lab at (617 724-3667) with FedEx or Credit Card # for Shipping**

_____ _____
**Date** **Patient Signature**

**Please fax this form back to the 3D Imaging Lab at 617-643-2992, thank you.**

Revised 5/16/11