MASS GENERAL
IMAGING

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

Form B: Authorization for Release of CT Dental Images

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

Patient Name:

____

(print please)

Medical Record #: __________________ **Date of Birth:** __________________________

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

Dentist's Name

____

Dentist's Phone #:

____

Mail To: (*check one*) ☐ **Patient** ☐ **New Dentist**

Mailing Adress: ____

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Date of Study: ____

Media Type: *(select one)*

The 3D Imaging Service will prepare the CD in the format required by your dentist's office.

- ☐ Simplant CD Version 7 to 16 *(licensed Simplant software required to edit)*
- ☐ Simplant Pro CD *(licensed Simplant Pro software required to edit)*
- ☐ Simplant View *(free download from Dentsply required to view)*
- ☐ DICOM CD

Please call the 3D Imaging Service at (617 724-3667) with a FedEx account number or credit card number for shipping.

Date __________________ ____
Patient Signature