FORM C

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 3RD Party Release of CT Dental Images

I, _____, Medical Record Number_____,
(print please)

authorize _____ to obtain my CT Dental images on my behalf.

NEW DENTIST'S NAME: _____

NEW DENITISTS' TELEPHONE#: _____

Date of CT Study: _____

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

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

_____ _____
Date **Patient Signature**

_____
Signature of Presenter

_____ _____
3D Technologist Initials **Relationship of Presenter**

☐ **Presenter's ID photocopied**

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

Revised 5/16/11