Invisalign Patient Transfer Form

This Patient Transfer Form notifies and authorizes Align Technology, Inc. its representatives, successors, assigns and agents (together "Align"), to transfer all of the patient's electronic Medical Records (described below) in its possession to New Treating Provider listed below.

PLEASE NOTE: INCOMPLETE FORMS WILL BE RETURNED UNPROCESSED

Patient information.

Patient name (Last, First) _____

Date of birth dd/mm/yyyy _____ / _____ / _____

Patient ID number _____

Patient Medical Records.

"Medical Records" include, but are not limited to, x-rays, scans, reports, charts, prescriptions, medical history, photographs, findings, plaster models or impressions of teeth, diagnosis, medical testing, test results, billing, and other treatment records on file with Align for treatment purposes.

RELEASE of patient by **Current Treating Provider.**

Please transfer the patient listed above out of my Invisalign Doctor Site including the patient's ClinCheck® files. I understand that by doing so, I relinquish all control of this patient to the New Treating Provider listed below. Align shall not be responsible for any cost, liability, or obligation resulting from my decision to transfer the patient to another provider for treatment or from transferring the Medical Records. I acknowledge that I am still responsible for any open balance incurred for this patient's treatment prior to the transfer.

Provider's Name (Please Print) _____

Provider's Invisalign ClinID _____

Provider's Signature _____

Date Signed _____

ACCEPTANCE of patient by **New Treating Provider.**

Please transfer the patient listed above into my Invisalign Doctor Site including the patient's ClinCheck files. I understand that by doing so, I accept and will assume full responsibility of any future Invisalign treatment charges. Align shall not be responsible for any cost, liability, or obligation resulting from transferring the patient or from my decision to accept the patient for treatment.

Provider's Name (Please Print) _____

Provider's Invisalign ClinID _____

Provider's Signature _____

Date Signed _____

Practice address (include street, city & postcode) _____

In some instances, Align may transfer a patient without authorization from the Current Treating Provider if the request is signed by both the patient and the New Treating Provider.

For the patient - Patient request and authorization for transfer.

This Patient Transfer Form authorizes correspondence with Align and any provider named above, verbally or in writing, regarding Medical Records and the transfer thereof, or other related information that may be (i) considered confidential under a national or state health, safety, or privacy code or (ii) otherwise considered individually identifiable health information.

I will not, nor shall anyone on my behalf, have any rights of approval, claims of compensation, or seek or obtain legal, equitable, or monetary damages or remedies arising out of use of my Medical Records that comply with the terms of this Patient Transfer Form. A copy of this Patient Transfer Form shall be considered as effective and valid as the original. This authorization shall be valid three years from the date I sign below.

I have read and understand the contents of this Patient Transfer Form.

Patients Name (Please Print) _____

Patient's Signature _____

Date Signed _____

If patient lacks the legal capacity to sign, the parent or legal guardian must also sign this form.

Legal Guardian / Parent Name and Relationship _____

Parent's Signature _____

Date Signed _____

Please send completed Patient Transfer Forms to your local Invisalign Customer Care by email to casetransfers@aligntech.com or by fax to: 408-790-0670