FAX COMPLETED FORM TO 408-790-0670

Please read below and sign in corresponding area to authorize Align Technology, Inc. to transfer patient:

PATIENT INFORMATION

Name (Last, First, Middle) _____

Gender: Female ☐ Male ☐

_____ / _____ / _____
Date of Birth mm/dd/yyyy

PATIENT #

_____
Patient Number

RELEASE OF PATIENT (CURRENT DOCTOR)

Transfer this patient 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 doctor. Align Technology, Inc. shall not be responsible for any cost, liability or obligation resulting from my decision to transfer the patient to another doctor for treatment. I acknowledge that I am still responsible for any open balance incurred in this patient's treatment prior to the transfer.

_____
Reason for Transfer

_____
Doctor's Name (Please print)

_____
Signature of Current Treating Doctor

_____
Practice Name

_____
Practice Address

ACCEPTANCE OF PATIENT (NEW DOCTOR)

Transfer the patient 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 charges incurred due to Mid-Course Correction, Treatment costs, Patient Refinement fees and any replacement Aligner/Retainer fees. Align Technology, Inc. shall not be responsible for any cost, liability or obligation resulting from my decision to accept the patient for treatment.

Doctor's Name _____

_____
Invisalign Username

_____
Signature of New Treating Doctor

_____
Practice Name

_____
Practice Address

_____
(Customer Care Representative handling transfer)

*In order to complete a Patient Transfer, it is desired that both the Invisalign® Trained Doctor that is transferring the patient, and the Invisalign® Trained Doctor that is accepting the patient, sign the transfer. However in some instances patients desire to transfer without authorization from their current doctor due to something that occurred during treatment, inability to locate the doctor or other similar reasons. As a result Align will accept a case transfer request if signed by patient and new doctor only. Each doctor agrees to indemnify, defend and hold harmless Align Technology, Inc. and its affiliates from and against any and all damages, losses, settlement payments, obligations, liabilities, penalties, claims, actions or causes of action, encumbrances and reasonable costs and expenses (including, without limitation, attorneys' fees and costs of investigation) suffered, sustained, incurred or paid by Align Technology, Inc. arising from this transfer. This form must be faxed to Align Customer Care at 408-790-0670.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION

Name (Last, First, Middle) _____

Gender: Female ☐ Male ☐

_____ / / _____
Date of Birth mm/dd/yyyy

PATIENT #

_____
Patient Number

The individual set forth above, or a representative thereof, is hereby authorizing the release of their personal medical records, from doctor _____ to doctor _____, an Invisalign® Trained doctor (hereinafter "New Doctor") for use by New Doctor in treatment with products from Align Technology, Inc.

This Authorization to Release Medical Records ("Release") includes, but is not limited to, x-rays, reports, charts, medical history, photographs, findings, plaster models or impressions of teeth, prescriptions, diagnosis, medical testing, test results, billing, and other treatment records in my doctor's possession ("Medical Records").

This Release also notifies and authorizes Align Technology, Inc., its representatives, successors, assigns and agents (collectively "Align") to transfer all Medical Records for the individual set forth above in its possession to New Doctor, wherein New Doctor will have electronic access to such records.

This Release also authorizes correspondence with Align or New Doctor, orally or in writing, regarding such Medical Records and the transfer thereof, or other medical information that may be (i) considered confidential under a state health or safety code, or (ii) considered "individually identifiable health information" as defined by the "Health Insurance Portability and Accountability Act" (HIPAA).

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 Release. A photocopy of this Release shall be considered as effective and valid as the original. This authorization shall be valid three years from its date. I have read and understand the contents of this Release.

This form must be faxed to 408-790-0670.

_____
Signature

_____
Print Name

_____
Address

_____
City, State, Zip

_____
Date

_____
Witness

_____
Print Name

_____
If signatory is under 21, the parent or Legal Guardian must also sign below to signify agreement

_____
Signature of Parent/Guardian

invisalign®

Align Technology, Inc.
(888) 822-5446
WWW.INVISALIGN.COM