Center for Custom Prosthetics

David Trainer
Maxillofacial Prosthetist

Jorge Franco Canales
Maxillofacial Prosthetist/Ocularist

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I here by Authorize any physician's office, hospital, or medical entity that has treated me, the undersigned, for any and all medical conditions to release the medical records of:

Patients Name:_____
Date of Birth:_____
Address: _____
Phone. Number:_____

To: Raymond E. Peters, Inc
Center. For Custom Prosthetics
1175 Creekside Parkway, Suite 400
Naples, FL 34108
Telephone 239-254-1648
Fax: 239-766-7528

I understand that these records are protected under Federal and/or State Law, and can NOT be disclosed without my written consent, unless otherwise provided by law.
By my signature below, I hear by, knowingly and voluntarily, authorize Center For Custom Prosthetics to request my health information.

_____. _____
Signature of Patient/ Parent/ Guardian Date

_____ _____
Printed Patient /Guardian/ Caregiver Name Relationship to Patient

PATIENT PHOTOGRAPH RELEASE

I hereby give permission to the Raymond E. Peters, Inc., (DBA Center For Custom Prosthetics) to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational or research purposes and to enhance the medical record. I further authorize the use of such audio-video material (video, audio, photographs, motion pictures and other resulting records) for teaching purposes to illustrate scientific papers or lectures at anytime hereafter without Inspection or approval on my part of the finished product or the specific use to which this material may be applied. I Hereby consent to any and all the above procedures

Social Media:

I authorized the use of any photos taken by Raymond E Peters Inc, (DBA Center for Custom Prosthetics) to be used in any social media engine (Facebook, Instagram, Webpage, ETC) to demonstrate quality, material, procedures, techniques, etc., that were preformed for me by Raymond E Peters Inc, (DBA Center for Custom Prosthetics) and their staff. Accept _____ Decline _____

_____ _____
Signature of Patient/ Parent/ Guardian Date

_____ _____
Printed Patient /Guardian/ Caregiver Name Relationship to Patient