21001 SYCOLIN RD, SUITE 100, ASHBURN, VA
20147
Phone: (571)291-9666, Fax: (571)291-9699
Email: Contact@vasmilesdental.com

RECORDS RELEASE REQUEST

Date: ___________________________

Patient's Name: ____

Patient Date of Birth: ____

I, undersigned, authorize Virginia Smiles Dental Care (Virginia Smiles, PLLC) to release my dental X rays ***and/or*** my dental records to me ***and/or*** person mentioned below***.*** I have requested Virginia Smiles Dental Care (Virginia Smiles, PLLC) to **Email** the Dental records indicated above.

Office Name: ____

Office Address: ____

Office Email: ____

Patient Print Name: ____

Patient Signature ____

Date: _________________________