Virginia Smiles Dental Care

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

RECORDS RELEASE REQUEST

Date:

Patient's Name:

Date of Birth:

I, under signed, 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

☐ FAX

☐ Email

☐ Prepare for pick-up

the Dental records indicated above.

NAME: _____

ADDRESS: _____
_____
_____

FAX: _____Email: _____

Print Name: _____

Signature: _____
Date: _____