# Authorization To Release Records

I, ______________________________, authorize the release of my records to:

☐ Myself

☐ ________________________________________ (relationship to patient)

☐ Dentist/Physician named below (include name and address)

________________________________________

________________________________________

________________________________________

________________________________________

Patient or GuardianSignature: ________________________________________

Date: ________________________

5284 Dawes Avenue
Alexandria, VA 22311