AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of _____ medical records to be
NAME OF PATIENT

sent to:

CENTER FOR DENTAL ANESTHESIOLOGY
5282 DAWES AVENUE
ALEXANDRIA, VA 22311

_____
NAME (PLEASE PRINT DOCTOR'S NAME)

_____
ADDRESS (PLEASE PRINT DOCTOR'S ADDRESS)

_____
ADDRESS (PLEASE PRINT DOCTOR'S A DDRESS)

_____
PHONE NUMBER (PLEASE PRINT DOCTOR'S NUMBER)

_____ _____
AUTHORIZED SIGNATURE DATE

RELATIONSHIP TO PATIENT: (please mark one)

☐ SELF ☐ PARENT ☐ SPOUSE ☐ CHILD ☐ OTHER: please explain below

_____

_____