CENTER FOR DENTAL ANESTHESIA

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