Records Release Request

Patient:____

Patient's Date of Birth: ______________________________

To (Doctor/ Physician): ____

Address:____

City: _____________________________________ State: _____________ Zip: ________________

Phone: __________________________________ Fax: _________________________________

I authorize the release of dental records relevant to dental treatment, including x-rays, charting and photographs, and request that they be transferred to:

Pinebrook Dentistry
Gloria Kim, DDS
24805 Pinebrook Road., Suite 311
Chantilly, VA 20152
Telephone: (703) 574-9070 Fax: (703) 574-9071
Email: info@pinebrookdentistry.com

____ ________________________________
Signature of Patient or Legal Representative Date