AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient Name _____Contact Phone Number_____

Patient Date of Birth_____

Patient Address _____

_____

At the request of the individual, I (patients name) _____do hereby

authorize _____

Phone Number:_____

Fax Number: _____

Address: _____

_____,

to release all my confidential health care information, including all history obtained, diagnostic notes, findings, treatment rendered, and x-rays to:

Tummarello & Pandak, DDS
11208 Waples Mill Road, Suite 101
Fairfax, VA 22030
(703)691-1511
Fax (703) 691-8455 email familydentistry1@hotmail.com

I understand my records are protected under Federal Confidentiality Regulations and under the General Laws of the State of Virginia and will not be disclosed without my written consent, except as otherwise specifically provided by law.

Any information to be released is authorized by this consent, and shall not be given, transferred, or relayed in any manner to any other person, other than stated above.

Signature of Patient/Representative or Guardian _____

Date (authorization will expire 12 months from date signed) _____