

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 _____
address: _____
fax number: _____ 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) _____