

## Release of Records Request

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

To \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to:

### **SHOHREH SHARIF, DDS**

3700 Joseph Siewick Drive, Ste 104 – Fairfax, VA 22033

Telephone (703)620-9122 Fax (703)620-6033

Patient(s) Name & DOB: \_\_\_\_\_

\_\_\_\_\_

Reason for request: \_\_\_\_\_

\_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/Guardian (Please Print)

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian