Release of Records Request

Today's Date: _____/_____/_____

SHOHREH SHARIF, D.D.S., P.C.
3700 Joseph Siewick Drive, Ste. 104
Fairfax, Virginia 22033
Phone (703)620-9122
Fax (703) 620-6033

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:

To: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Telephone: (_____) _____-_____ Fax: (_____) _____-_____

Patient(s) Name & DOB: _____

_____

Reason for the Transfer: _____

_____

(A $5.00 fee will be collected upon request)

Parent/Guardian Name (Print): _____ **Relationship:** _____

Signature: _____ **Date:** _____/_____/_____