Greater Washington DENTISTRY
PEDIATRICS | ORTHODONTICS | GENERAL
Shohreh Sharif, D.D.S. & Associates P.C.

Release of Records Request

Today's Date: _____/_____/_____

To: _____

Address: _____

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

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: **Mail:** _____ **Email:** _____ DDS.SHARIF@GMAIL.COM

Greater Washington Denstistry
Shohreh Sharif, D.D.S. P.C. & Associates

3700 Joseph Siewick Dr., Suite 104
Fairfax, Virginia 22033
Phone (703)620-9122

8626 Lee Highway, Suite 205
Fairfax, VA 22031
Phone (703)992-9222

Patient(s) Name & DOB: _____

_____

_____

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

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