

Authorization For Release of Records

Patient Information:

Name: _____ Date of Birth: _____

Release My Records From:

Name: _____

Tel: _____

Fax: _____

To:

Richard T. Stone, DDS
203 E. Oxford Avenue
Alexandria, VA 22301

Tel: 703-548-5042

Fax: 703-548-2832

I Authorize Release of My Records

Patient Signature: _____ Date: _____