STONE
aesthetic dentistry

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

Email: Office@StoneDDS.com

I Authorize Release of My Records

*Patient Signature:*_____

*Date:*_____