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: stonedentistry@yahoo.com

I Authorize Release of My Records

Patient Signature:_____ Date:_____