

**AUTHORIZATION TO RELEASE
DENTAL RECORDS**

I _____ hereby authorize
Dr. _____ to release a photocopy of my
dental treatment records and originals or duplicates of any
current x-rays to the office of:

**William R. Stringham D.D.S., P.C.
3545 Chain Bridge Road Suite. 5
Fairfax, VA 22030
703-273-5545
703-591-8702 (Fax)**

Additional Family Members:

Patient _____	DOB _____
Patient _____	DOB _____
Patient _____	DOB _____
Patient _____	DOB _____

Respectfully,