

**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)**  
***Email: billstringham@stringhamdental.com***

Additional Family Members:

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

Respectfully,