Records Release/Request

To:_____

Adress:_____

City:_____ **State:**_____ **Zip:**_____

I hereby authorize and request the release of my dental records and x-rays or copies of such and request that they are transferred to:

Burke Dental, PLLC
9006 Fern Park Drive, Suite A
Burke, VA 22015-1676

Phone: 703-978-6000
Fax: 703-978-5089
Email: info@BurkeDental.com

As the person signing this consent, I understand that I am giving my permission to the above-named provider for disclosure of confidential healthcare records. I also understand that I have the right to revoke this consent, but that such revocation is not effective until it is delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the providers, persons, or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent, unless such recipient is a provider who makes disclosure permitted by law.

_____

Print Patient Name

_____ _____

Signature of Patient/Parent/Guardian **Date**