Please mail dental records and x-rays to:

Burton Dentistry, P.C.
1900 Elkin Street, Suite 290
Alexandria, Virginia 22308
www.burtondentistry.com
703-799-4300 Fax: 703-799-4575

Consent for Records Release

I _____ hereby authorize the release the following dental records and x-rays to Burton Dentistry, P.C.

Patient(s) Name: _____

Address: _____

City, State, and Zip: _____

Telephone number: _____

From the following dental office:

Previous Dentist's Name: _____

Address: _____

City, State, and Zip: _____

Telephone number: _____

Fax Number: _____

This authorization is limited to the release of information of the person or organization and to no others. I understand this consent will expire when the information has been released or when it has been revoked by me.

_____ _____

Patient Signature Date