Francesca Burton DDS
1900 Elkin Street, Suite #290
Alexandria, Virginia 22308
703-799-4300

Consent For Records Release

I, _____, hereby authorize Dr. Burton's office to release the following dental records: (list all family members' name)

Name: _____
Telephone number: _____

To the following dental office:

Name: _____
Address: _____
City, State, and Zip: _____
Telephone 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 I understand this consent will expire when the information has been released or when it has been revoked by me.

Please email form back to burtondentistry@outlook.com. Please allow 3 business days for completion.

_____
Patient Signature

Comments/Reason for Leaving:

_____
_____
_____