OAKTON FAMILY
DENTISTRY

Date: _____

To Whom It May Concern:

I am requesting and do hereby give my permission to release my records electronically **to:**

OAKTON FAMILY DENTISTRY

Records may be sent via email: **smiles@oaktonfamilydentistry.com**

Or Mail Records to: Oakton Family Dentistry
3050 Chain Bridge Road
Suite 201
Fairfax, VA 22030

Phone: 703-281-6201
Fax: 703-281-6208

I appreciate your cooperation in this matter and can be reached at the phone number listed below if you have any questions.

Thank you,

Patient Name_____

Patient or Guardian Signature_____

Phone Number _____

Records to be released from:

Dentist Name_____

Dentist Number_____

Dentist Fax Number_____