AUTHORIZATION TO RELEASE DENTAL RECORDS

(In compliance with Virginia Statutes § 32.1-127.1:03 and § 8.01-413)

I _____ DOB: _____hereby authorize

Dr._____

to release a photocopy of my dental treatment records and originals, or duplicates, of any previous x-rays to the office of:

Jason Campbell D.D.S.

Seaside Dentistry

3300 Princess Anne Rd., Suite 715

Virginia Beach, VA 23456

757-689-4363

757-689-2579 (Fax)

Email: Contactus@SeasideDentistryVB.com

Additional Family Members (under the age of 18):

Patient:_____ DOB:_____

Patient:_____ DOB:_____

Patient:_____ DOB:_____

Patient:_____ DOB:_____

Patient:_____ DOB:_____

Respectfully,

Signed: _____ Date:_____