RECORDS RELEASE REQUEST

Date_____

I authorize the release of dental and medical records, to include but not limited to radiographs, I/O photos and possible treatment plans, relevant to dental treatment, or copies of such, and request that they be released to:

E. Alexander White & Bradford R. Thweatt, DDS, PC
5500 Whiteside Road
Sandston, VA 23150
804/737-4444 (phone)
804/328-2865 (fax)
Email: whiteandthweatt@sandstondds.com

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Signature of Patient (Guardian, if minor) Print Name