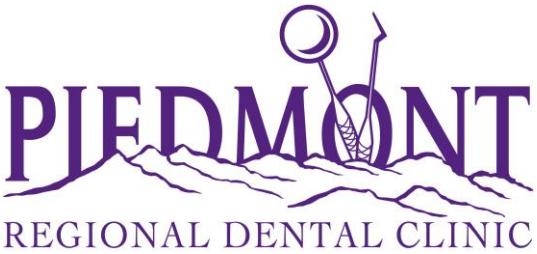

13296 James Madison Highway
Orange, Virginia 22960
540-661-0008
www.vaprdc.org

Authorization for Release of Dental Records

Patient Name: _____ Date of Birth: _____

Authorizes Piedmont Regional Dental Clinic to release my dental records to the following entity/provider:

Entity / Provider's Name: _____

Address: _____City: _____State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

_____Please release a full copy of my dental/or medical records

_____Please release only the specific information requested

_____Please release only the following information: _____

EXPIRATION: This Authorization is good for one year unless specific date range is requested in writing.

By signing, I am authorizing Piedmont Regional Dental Clinic to disclose my dental records to the entity or provider listed above. I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by Piedmont Regional Dental Clinic.

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE:

_____Date: _____

If signed by a person other than the patient, please indicate relationship:

_____