Records Release / Request

(for sending records to the Office of Jamie Park DDS & Assoc.)

To: _____
Doctor / Practice Name

Address: _____
Doctor / Practice Street Address

_____ ST _____ ZIP Code
City

I hereby authorize the release of my records, including treatment plans or notes, and most recent x-rays (both bite-wings and panoramic), to the following office:

Office of Jamie Park DDS & Associates
10680 Main Street
Suite 150
Fairfax, VA 22030

Please prepare and...

❑ mail to the office above OR ❑ hold for me to pick up OR ❑ FAX them to 866-763-9957 OR ❑ E-mail them to: contact@jamieparkdds.com

SPECIAL NOTE REGARDING MY X-RAYS:

If my x-rays are maintained in electronic form, instead of providing them in printed form, please e-mail them in their **original / maximum** and **full-size**, in either "JPG" or Dentrix's "VNS" format, to: contact@jamieparkdds.com

Patient Printed Name: _____ Patient Date of Birth: _____

Patient Signature: _____ Date: _____

Patient Telephone: _____