ESTHETIQUE DENTISTRY
44345 Premier Plaza, Suite 220
Ashburn, VA 20147
Phone (703) 729-6222 Fax: (703) 729-6221
Email: smiles@esthetiquedentistry.com

I, _____, authorize _____ to release

dental records and x-rays to_____.

Patient Name:_____
Patient Date of Birth:_____

Please Send Records to:_____.

Additional Records: _____

_____ _____

Signature Date

If this consent is signed by a parent or guardian on behalf of the patient please state the relationship to the patient_____.