



Patient Release of Information:

I authorize the Doctor and Staff of:

Dentist: _____

Address: _____

Telephone: _____

Fax: _____

Email: _____

To release any information contained in my dental records and any applicable dental radiographs that are relevant to my dental treatment history. **Please send the requested information to:**

Elaine K. Sours, D.D.S., P.C.
8719 Plantation Lane
Manassas, VA 20110-4506
Office: 703-369-5544 / Fax: 703-361-3680
drsours@soursdental.com

Patient's Name: (Please Print) _____

Patient's Signature _____
(Or parent/legal guardian if patient is a minor)

Date _____