

Family & Cosmetic Dentistry
Elaine K. Sours ♥ D.D.S., P.C.



Patient Release of Information

I authorize the Doctor and Staff of:

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

Dentist: _____

Address: _____

Telephone: _____

Email: _____

Patient's Name: (Please Print) _____

Patient's Date of Birth: _____

Patient's Signature _____

(Or parent/legal guardian if patient is a minor)

Date _____