

Records Release/Request

To: _____
Dentist/ Office Name

Address: _____

I am requesting to forward my records, including treatment plans and notes and most recent Xrays (bitewing and panoramic) to the following office:

John S.K. Hsu D.D.S. and Virginia J. Chin D.D.S., P.C.
10801 Main St. Ste 500 and 600
Fairfax, Va 22030

Documents and Xrays can also be forwarded to healthysmilesva@juno.com

Patient Name: _____

Patient's Date of Birth: _____

Today's Date: _____

Patient's Telephone Number: _____

Patient's Signature: _____