AUTHORIZATION TO RELEASE
DENTAL RECORDS

I _____ hereby authorize
Dr._____ (Previous Dentist) to release a copy of my dental treatment records and any current x-rays to the office of:

Katherine McGrath D.D.S., F.A.G.D.
Woodson Square
9679- A Main Street
Fairfax, VA 22031
703-978-6556 (Office Phone)
703-426-1405 (Fax)
E-mail: kamcgrathdds@hotmail.com

Additional Family Members:
Patient_____ DOB_____
Patient_____ DOB_____
Patient_____ DOB_____
Patient_____ DOB_____

Respectfully,

_____ (Signature)