Quang C. Tran D.D.S
5413-D Backlick Road
Springfield, VA 22151
703-256-4243

AUTHORIZATION OF RELEASE OF INFORMATION

Patient Information: ____

Last Name First Name Middle Intital

____

Date of Birth SSN#

I hereby request and authorize Dr. Quang C. Tran to send a copy of the following reports from the patient's record:

X-rays Full Dental Records

To be released to:

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I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law that is applicable to ANY and ALL of the above. I will be responsible of the x-ray duplicate fee of $20.

My signature below authorizes released of all such information.

______________________________ ______________

Signature of Patient or Responsible Party Date

______________________________ ______________

Witness Date

I, the above signed, understand that I may revoke this consent at any item except to the extent that action has been taken in reliance on it. This consent will expire upon completion of the transaction and no later than ninety (90) days from the date signed, unless otherwise stated herein.

To be party receiving this information: This information has been disclosed to you from the records, whose confidentially is protected by Federal and/or state regulations prohibiting you make further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.