



Center for Dental Anesthesiology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of _____ medical records to be
NAME OF PATIENT

sent to:

CENTER FOR DENTAL ANESTHESIOLOGY
5282 DAWES AVENUE
ALEXANDRIA, VA 22311

NAME (PLEASE PRINT DOCTOR'S NAME)

ADDRESS (PLEASE PRINT DOCTOR'S ADDRESS)

ADDRESS (PLEASE PRINT DOCTOR'S ADDRESS)

PHONE NUMBER (PLEASE PRINT DOCTOR'S NUMBER)

AUTHORIZED SIGNATURE

DATE

RELATIONSHIP TO PATIENT: (please mark one)

SELF PARENT SPOUSE CHILD OTHER: please explain below

JAMES A. SNYDER, D.D.S.

KEVIN MISTRY, D.D.S.

DENNIS AHL, D.M.D.

NADGIE ORTIZ-DIAZ, D.M.D.

5284 DAWES AVENUE

ALEXANDRIA VA 22311

(703) 379-6400

(703) 379-6407 FAX

www.jamesasnyderdds.com
cda5284@gmail.com