



Center for Dental
Anesthesiology

Authorization To Release Records

I, _____, authorize the release of my records to:

- Myself
- _____ (relationship to patient)
- Dentist/Physician named below (include name and address)

Patient or Guardian Signature: _____

Date: _____

5284 Dawes Avenue
Alexandria, VA 22311
Ph: (703) 379-6400 / Fax (703) 379-6407
cda5284@gmail.com
www.jamesasnyderdds.com