Family & Cosmetic Dentistry
Elaine K. Sours D.D.S., P.C.
and Associates

Patient Release of Information

I authorize the Doctor and Staff of:

Dentist: _____

Address: _____

_____

_____

Telephone: _____

Email: _____

To release any information contained in my dental records and any applicable dental radiographs that are current to my dental treatment history. Please send the requested information to:

Elaine K. Sours, D.D.S ., P.C.
8719 Plantation Lane
Manassas, VA 20110-4506
Ph 703-369-5544
Fax 703-361-3680
info@soursdental.com

Patient's Name: (Please Print) _____

Patient's Date of Birth: _____

Patient's Signature _____
(Or parent/legal guardian if patient is a minor)

Date _____