FAIRFAX PERIODONTAL GROUP
PERIODONTICS AND DENTAL IMPLANTS

X-Ray and Records Release Form

I, _____:
(Please print)

Authorize the release of my dental records, including copies of radiographs, treatment records and medical history to be sent to:

Fairfax Periodontal Group
8260 Willow Oaks Corporate Dr., Suite #525
Fairfax, VA 22031

If you are able to provide digital x-rays please e-mail documents to:
contact@fairfaxperiodontist.com

_____
(Patient signature or Legal Guardian signature)

Date: _____ / _____ / _____

8260 Willow Oaks Corporate Dr.
Suite 525
Fairfax, VA 22031
T: 703-639-0245
www.fairfaxperiodontist.com