



AUTHORIZATION FOR DISCLOSURE OF DENTAL RECORDS

Patient Name: _____

Date of birth: _____

Address: _____

Telephone: _____

Email: _____

I, _____ authorize Broadway Dental Associates to Transfer My/dependent
(_____) dental records including X-rays, clinical notes
and treatment plan to _____.

Covering the period of healthcare from _____ to _____.

For the purpose of: _____.

Transfer the records to the email: _____.

Name of the patient: _____

Date of Request: _____

Signature of the Patient or Legal Representative: _____

Note: Allow us 5 to 7 bussiness days to provide the Dental Records.

☎ 703-533-8668

☎ 703-988-7133

✉ info@broadwaydentalnova.com

📍 815 W Broad St, Falls Church, VA 22046