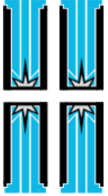

H. Gakavian, DDS, PA
2415 MUSGROVE ROAD, SUITE 205
SILVER SPRING, MD 20904
301.236.0660

AUTHORIZATION FOR RELEASE OF INFORMATION

I Hereby Authorize:

____

Name of Dentist / Office

____

Address

____

City State Zip Code

To Release My Records/Radiographic Images To:

____

Name of Dentist / Office

____

Address

____

City State Zip Code

PATIENT NAME:____

Additional family member (adult members require individual signatures). Kindly submit $25 per records requested.

____

____

____

I understand that this authorization expires three months from the date of my signature below

____

Signature Date