

General Dental Release

Please provide me with copies of all of my dental records, x-rays, medication sheets, interpretations of tests, and progress notes pertaining to my dental treatment. I understand that the custodian of my actual dental record is my dentist. I understand that the information contained in the record belongs to me. I agree to accept copies of such records and to pay any fee(s) for duplication as required.

Patient Signature _____ Date _____

Date of Birth _____

Please send to: Thomas Family Dentistry

33820 Old Valley Pike

Suite 1

Strasburg, VA 22657