Dear Office of _____,

In accordance with the Code of Virginia 32.1-127.1:02, I hereby authorize and request you to release my dental records, dental x-rays, history, reports, and any other pertinent information to:

Name: Robert A. Levine, DDS
(where records are to be sent)

Address: 3918 Prosperity Ave., #203
Fairfax, VA 22031-3333

Phone #: (703) 280-1300

or email: LevineFairfax@gmail.com

Thank you!

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____

Patient/Guardian Phone # : (_____)_____
(in case of a question)