

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 x-rays 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)