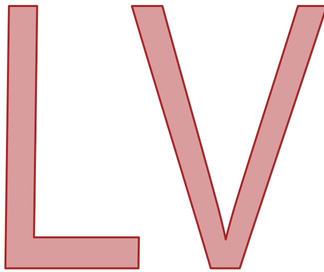

Virginia Dental Group, PLLC
3911 Old Lee Hwy, Ste 42C Fairfax, VA 22030
Office (703) 385-3800 Fax (703) 890-0084
www.virginiadentalgroup.com

X-ray and Dental Records Release Form:

I (print patient's or guardian's name) ___________________________hereby authorize the release records concerning (patient's name (s): ________________________________
Dental health and copies of x-rays and all dental records to:

***By mail to: ____**

***Address: ____**

***Phone Number: ____**

***Email records and x-rays to: ____**
(Please print clearly)

By selecting Digital Copy you take full responsibility that the private dental records are going to be sent over the internet without security and the ability to verify that receiving party successfully obtained the files. Further more there is an understanding that the file format may not be compatible. We issue all x-rays in JPEG program.

I understand that the x-rays are part of the original dental records that belongs to VIRGINIA DENTAL GROUP PLLC the parent company of the dental office. We require 48 hours from the time of signature to process your request.

Please note that this form MUST be filled fully including your Signature, Date & Time, and the Drivers License Number that matches your original number when originally given to the practice. Please email the completed form to virginiadentalgroup@yahoo.com or you may fax it to (703) 890-0084.

Signature of patient OR of legal guardian____

Date: ______________________ License #__________________DOB#_____________

Reason for the release:

☐ Second Opinion ☐ Moving ☐ Insurance Change
☐ Not Happy with the practice

LIDA M. VARGAS DDS
SANTIAGO J. RUEDA DDS
TAEHEON KANG, DDS, MS