Bogacki & Bogacki, DDS PC

8344 Traford Lane, Suite 3D Springfield, Virginia 22152 703-451-2867 f/703-991-8448

Records Release Request

I, _____, hereby request and authorize _____to disclose and provide copies of any and all clinical treatment records and information concerning my care, which is in the possession of this person/entity to the above address along with any family members listed below:

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs (x-rays), clinical photos, treatment plans, treatment records, referral and consultation recommendations and reports and diagnostic models to their related materials, We have the capability to receive electronic digital images at admin@bogackidental.com.

I expressly release from liability the above mentioned person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

Signature of Patient/Guardian:_____

Date:_____