RECORDS RELEASE FORM

WASHINGTON CENTER
for Cosmetic Dentistry

To: Dr.____

Phone#: (____) ______-__________Fax# (___) _______-________

Please forward all of my **records** and **x-rays** to Washington Center for Cosmetic Dentistry. Please contact me if you have any questions at (______) _______________

Patient Name: ____________________________ DOB: _______________

Signature: ________________________________ Date: ________________

From: The Office of Drs. Pollowitz & Brown
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Washington, DC 20016
Email: wccd@amazingdentistry.com
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