

## Records Release / Request

To: \_\_\_\_\_  
Doctor / Practice Name

Address: \_\_\_\_\_  
Doctor / Practice Street Address

\_\_\_\_\_  
City ST ZIP Code

I hereby authorize the release of my records, including treatment plans or notes, and most recent x-rays (both bite-wings and panoramic), to the following office:

**Office of Drs. Jamie Park, Carolyn Chang & Audrey Maiurano**

10680 Main Street  
Suite 150  
Fairfax, VA 22030

Please prepare and...

mail to the office above

OR

hold for me to pick up

OR

FAX them to 866-763-9957

OR

E-mail them to: [contact@jamieparkdds.com](mailto:contact@jamieparkdds.com)

### **SPECIAL NOTE REGARDING MY X-RAYS:**

If my x-rays are maintained in electronic form, instead of providing them in printed form, please e-mail them in their **original / maximum** and **full-size**, in either "JPG" or Dentrix's "VNS" format, to: [contact@jamieparkdds.com](mailto:contact@jamieparkdds.com)

Patient Printed Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Telephone: \_\_\_\_\_