

**DENTAL ARTS**

<b>Rosslyn Dental Arts Center</b> 1000 Wilson Blvd. #M745 Rosslyn VA 22209 (703)527-6453	<b>Tyson Dental Arts Center</b> 8304-C Old Courthouse Rd. Vienna VA 22182 (703)356-1200	<b>Chantilly Dental Arts Center</b> 13655-A Lee Jackson Hwy. Chantilly VA 20151 (703)263-7222	<b>Crystal City Dental Arts Center</b> 1235-S Clark St. Ste #201 Arlington VA 22202 (571)267-1400
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**Request for Records**

I request the copies of \_\_\_\_\_'s dental X-Rays be:  
(Name of Patient)

\_\_\_\_ Released to Patient

\_\_\_\_ Released to the Following Dental Office:

Name of Doctor: \_\_\_\_\_.

Street Address: \_\_\_\_\_.

City, State, Zip: \_\_\_\_\_.

Telephone: \_\_\_\_\_.

- Reason for Obtaining Patient Records: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

There may be a fee for obtaining copies of Records. You will be informed if there is a cost.

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

\_\_\_\_\_  
Date