



Greater Washington
DENTISTRY
PEDIATRICS | ORTHODONTICS | GENERAL
Shohreh Sharif, D.D.S. & Associates P.C.

Release of Records Request

Today's Date: ____/____/____

To: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ - _____ Fax: (____) _____ - _____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to: Mail: _____ Email: _____ DDS.SHARIF@GMAIL.COM

Greater Washington Dentistry Shohreh Sharif, D.D.S. P.C. & Associates

3700 Joseph Siewick Dr., Suite 104
Fairfax, Virginia 22033
Phone (703)620-9122

8626 Lee Highway, Suite 205
Fairfax, VA 22031
Phone (703)992-9222

Patient(s) Name & DOB: _____

Parent/Guardian Name (Print): _____ Relationship: _____

Signature: _____ Date: ____/____/____