Records Release Request

Date_____

Patient's Name_____

I authorize the release of dental records and medical records relevant to dental treatment or copies of such and request they are transferred to:

Andrew G. Gilfillan, DDS

491 McLaws Circle, Suite1
Williamsburg, VA 23185
(757)253-0598
Fax: (757) 253-7909

_____
Patient/Parent/Guardian Signature (Responsible Party)