Posh Dental Arts
*12070 Old Line Ctr, Suite 101*
*Waldorf, MD 20602*
*Phone: 301-645-8530*

# Release of Records Request

**Today's Date: _______/_______/_________**

**Posh Dental Arts**
**Babak Seihoun D.D.S. & Associates**
12070 Old Line Centre, Suite 101
Waldorf, MD 20602
Phone (301)645-8530 Fax (301)845-8570

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_______**

**To:** ____________________________________________________________________________

**Address:** ________________________________________________________________________

**City:** __________________________________ **State:** ____________________ **Zip:** __________________

**Telephone: (_________)** _________-_____________ **Fax: (_________)** _________-_______________

**Email:** __________________________________________________________________________

**Patient(s) Name & DOB:** __________________________________________________________________

______________________________________________________________________________________

**Reason for the Transfer:** __________________________________________________________________

______________________________________________________________________________________

**Parent/Guardian Name (Print):** ________________________________ **Relationship:** ________________

**Signature:** ______________________________________________________________________

**Date:** __________/__________/____________