RECORDS RELEASE FORM

WASHINGTON CENTER
for Cosmetic Dentistry

To: Dr._____

Phone#: (____) _____-_____Fax# (___) _____-_____

Please forward all of my **records** and **x-rays** to Washington Center for Cosmetic Dentistry. Please contact me if you have any questions at (_____) _____

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

From: The Office of Drs. Pollowitz & Brown
4910 Massachusetts Ave. NW Suite 204
Washington, DC 20016
Email: wccd@amazingdentistry.com
P 202-244-4477
F 202-244-3273