



AUTHORIZATION FOR RELEASE OF PATIENT RECORD INFORMATION
TO PATIENT AND / OR NEW DENTAL OFFICE

Stephen D. Burch, D.D.S.

Diplomate, I.C. I.
Diplomate, A.S.O.
Fellow A.G.D

Name of Patient _____

Address of Patient: _____

Number & Street

City

State

Zip

Sedation Dentistry

General Dentistry

Reconstructive Dentistry

Neuromuscular Dentistry

Periodontal Therapy

Treatments for TMJ,

Head, Neck & Face Pain

Smile Rejuvenation

*Comprehensive Dental
Implant Service*

Social Security # _____ Date of Birth: _____

I hear by authorize: Stephen E. Burch, D.D.S. Ltd. trading as
Sedation Dental Centre & Spa Of McLean

to release _____

the following Information : Dental History and X-rays

Covering the period of care from _____ to _____

I understand I may revoke this consent at any time except to
the extent that action has already been taken on it and that it
will expire automatically ninety days from the date below.

Dr. Stephen E. Burch and the corporation for Sedation Dental
Centre & Spa of McLean are hereby relieved all legal respon-
sibility or liability for the release of the information described
above to the extent indicated and authorized herein.

8270 Greensboro Dr.
#101
McLean, VA 22102

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Fax: 703-827-9256

E-Mail & Web Info:
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www.SedationDentalCentre.com

Signature of Patient or Legal Guardian

Date