MADJID MATIN DMD, LLC
PERIODONTICS AND IMPLANT DENTISTRY
5530 WISCONSIN AVENUE
SUITE 1110
CHEVY CHASE, MD 20815
TEL: 301.656.6424
FAX: 301.656.6425

Authorization for the Release of Dental Records

Patient name: **Date:**

I hereby authorize Dr. _____ to release the information contained in my dental records to Madjid Matin, DMD, LLC.

Email to:

admin@chevychasedental.com

I recognize that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties.

Mail to:

Madjid Matin, DMD
5530 Wisconsin Avenue, Suite# 1110
Chevy Chase, MD 20815

Any and all information may be released including, but not limited to xrays, photos, intra oral pictures, and clinical notes.

This authorization is effective now and will remain in effect until _____(date)

Signature_____
Date_____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient