Dental Care of Mclean
6711 Whittier Avenue, Suite 201
Mclean, VA 22101
(703)356-2020
DentalCare@McLeanDDS.com

Dental Care of Alexandria
1451 Belle Haven Road, Suite 430
Alexandria, VA 22307
(703)765-6400
DentalCareofAlexandria@gmail.com

Records Release to our office

I, ___________________________________authorize the Practice of: ______________________________
to release all records & x-rays to the practice of John A. Schehl D.D.S., P.C. / Dental Care of McLean for the following patient(s):

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I understand that the practice of**:**_____________________________will not be held responsible for original records after they have been copied, scanned, emailed, mailed, or removed from their office. I understand these records may be original and or copied records, which may remain in the office of **John A. Schehl, D.D.S., P.C./Dental Care of McLean** for a minimum of 3 years.

I authorize **John A. Schehl, D.D.S., P.C./Dental Care of McLean** to receive the above patient records to the following location:

Doctor/Practice/Patient: John A. Schehl, DDS, PC/Dental Care of McLean/Dental Care of Alexandria

Email Address: DentalCare@McLeanDDS.com or DentalCareofAlexandria@gmail.com

Fax #: McLean- (703) 556-9352, Alexandria- (703) 765-6444

Address: McLean or Alexandria (address listed above)

I have read the above information and give my consent for all records to be released and sent to the office of John A. Schehl, D.D.S., P.C./Dental Care of McLean.

Patient Signature: ____ **Date:** _____________________

Witness Signature: ____ **Date:** _____________________