Venkat N. Reddy, DDS, LLC
10401 Old Georgetown Road, Bethesda, MD 20814
☎ (301) 530-4300 | 🖷 (301) 530-6209 | ✉ vrsmiles@gmail.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security # (optional): _____

I request and authorize _____ to release dental information of the patient named above to:

Name: VENKAT N REDDY, DDS

Address: 10401 OLD GEORGETOWN RD. SUITE 210

City: BETHESDA State: MD Zip: 20814

This request and authorization applies to:

☐ Dental information relating to the following treatment, condition, or dates: _____

☐ X-Rays
☐ All dental information
☐ Other: _____

Patient Signature: X_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Date Signed: _____