Venkat N. Reddy, DDS, LLC
6000 Executive Blvd STE 525, North Bethesda, MD 20852
☏ (301) 530-4300 | ✉ 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: 6000 Executive Blvd STE 525

City: North BETHESDA State: MD Zip Code: 20852

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: _____