

RECORDS RELEASE/REQUEST

To: _____

Address: _____

City _____ State: _____ Zip: _____

I hereby authorize the release of a copy of my medical records and request that they be sent to:

Dr. Anthony B. Sims D.D.S., P.C
8865 Stanford Boulevard
Suite •131
Columbia, MD 21045
Telephone: (410) 872-0872
Fax: (410) 872-0874

Print name of Patient

From: _____ To: _____
Date of Records

Patients Signature: _____ Date: _____