



PROSTHO.
ENDO.

Bethesda | Rockville | Vienna

Request for Patient Records

Thank you for calling the office of Drs DJ Shin, DMD, MS, and Ana Kim, DMD, Prosthodontics. Dental Specialists. **Please complete the Release Authorization Form below and forward it to your current dentist** to request a complete copy of your dental records and radiographs.

Thank you.

Release Authorization Form

Name: _____

Date of Birth: _____

Address: _____

Signature _____

Date _____

I request that a complete copy of x-rays and/or, if applicable, referral slip, to be forwarded to the office of:

Prosthodontics. Endodontics. Dental Specialists

5904 Hubbard Dr, North Bethesda, MD 20852

311 Maple Ave W, Suite J, Vienna, VA 22180

Email: records@prosthodontics-dent.com

Phone: 301-377-8306

Fax: 301-597-7757