nishanhalimdmd

27 Sixth St, NE Washington, DC 20002

o: 202.543.2020 info@nishanhalimdmd.com f: 866.230.0913

www.nishanhalimdmd.com

Record Release Authorization

Dr.____

Address:____

Telephone: ____

Email:____

I herby authorize the release of my dental records and x-rays to the office of Dr. Nishan Halim.

Please submit records to:

Nishan Halim, DMD
27 Sixth St, NE
Washington, DC 20002

o: 202.543.2020
f: 866.230.0913
e: info@nishanhalimdmd.com
www.nishanhalimdmd.com

Thank you in advance for your cooperation.

Patient Name:_________________________________Date of Birth:____________

Signature/Guardian: ____________________________Date:__________________