



BARKLEY BOULEVARD DENTAL CARE

Records Release Form

Patient's First Name: _____ Last Name: _____

Phone Number: _____ Date of Birth: _____

I authorize Dr. Les Seelye DDS, Barkley Boulevard Care, to release the information listed below to the organization, agency, or individual names on this request.

I request the release of dental records relevant to dental treatment, or copies of such.

Dentist or Practice Name: _____

Phone: _____ Email: _____

Records Included:

<input type="checkbox"/> BWX	<input type="checkbox"/> Pano	<input type="checkbox"/> Perio Chart
<input type="checkbox"/> Date of SRP	<input type="checkbox"/> Date of Last Cleaning	<input type="checkbox"/> Diagnostic Casts
<input type="checkbox"/> Reports	<input type="checkbox"/> Photos	<input type="checkbox"/> Treatment Record
<input type="checkbox"/> Other:		

Purpose of Release:

<input type="checkbox"/> Personal	<input type="checkbox"/> Transfer Providers	<input type="checkbox"/> Attorney/Legal
<input type="checkbox"/> Other:		

Signature of Patient or Guardian: _____ Date: _____

Please e-mail all records requested to: Barkley.Dental@comcast.net