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:

☐ BWX	☐ Pano	☐ Perio Chart
☐ Date of SRP	☐ Date of Last Cleaning	☐ Diagnostic Casts
☐ Reports	☐ Photos	☐ Treatment Record
☐ Other:		

Purpose of Release:

☐ Self/Person Records	☐ Transfer Providers	☐ Attorney/Legal
☐ Other:		

Signature of Patient or Guardian: _____ Date: _____

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