

AUTHORIZED RECORDS RELEASE

DATE: _____

PATIENT NAME: _____

ADDRESS : _____

PHONE: _____ **DOB:** _____ **SS#** _____

(Name and Address of Previous Dentist)

(PHONE) (EMAIL)

(Signature) (Date)

I authorize the release of my entire dental record including all radiographic images to:

**WILLOW TREE DENTAL
CHRISTOPHER L. SEESE, D.M.D
5000 HAMPTON CENTER, SUITE 2
MORGANTOWN, WV 26505
PHONE: (304) 598-0400
FAX: (304) 598-0444
EMAIL: smile@willowtreedentalwv.com**

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