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

IMPORTANT NOTICE: