

Records Release

Roxanne Siegrist, DDS | 510 Elk Avenue | Suite 2 | Crested Butte, CO 81224

Please release records to:

Doctor 's name: _____

E-mail address: _____

Phone: _____

Fax: _____

Mailing address: _____

City: _____

State: _____

Zip code: _____

Information requested:

- Copy of complete dental chart
- Copy of dental radiographs
- All treatment rendered by this office
- The following dates: _____

Reason for request:

- Transfer of records
- Second opinion
- Other: _____

Authorization:

Please release the information specified above from:
Dr Roxanne Siegrist
PO Box 639
Crested Butte, CO 81224
Fax: 970-349-5578
E-mail: siegristdds@gmail.com

I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. A copy of this Authorization or my signature thereon may be used with the same effectiveness as the original.

NOTES: _____

Today's date: _____

Patient name: _____

Patient date of birth: _____

Patient or guardian signature: _____