Records Request

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

Please release records from:

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 to :
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: ______________________________