LASHLEY
FAMILY
DENTISTRY

COMPLETE FAMILY AND COSMETIC DENTISTRY

RECORDS REQUEST

Date: _____

DENTAL OFFICE:_____
(NAME OF PREVIOUS DENTAL PROVIDER)

Address:_____

City:_____State: _____Zip:_____

I authorize the release of all dental records (current x-rays, FMX, clinical history) and/or medical records relevant to dental treatment that has been performed in the above listed office and request that they are transferred to the following office:

Lashley Family Dentistry

Dr. Craig Lashley, D.D.S.
Dr. Alexandra Seltenreich, D.D.S
Dr. Rebecca Twietmeyer, D.D.S.
2105 N Ridge Road – Wichita, KS 67212
Digital Records can be emailed to: erica@lfd.dentist

_____

Patient's Name & D/O/B
(Please include all additional family members if necessary)

Signature of Patient (Guardian)