LASHLEY
FAMILY DENTISTRY

RECORDS RELEASE REQUEST

Date:_____

To:_____
(NAME OF PREVIOUS DENTAL PROVIDER)

Address:_____

City:_____State:_____Zip:_____

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

Lashley Family Dentistry

Dr. Craig B. Lashley, D.D.S.– Dr. Alexandra N. Seltenreich, D.D.S.
2105 N Ridge Rd - Wichita, Kansas 67212
Telephone: (316) 773-1177 - Fax: (316) 773-2693
Can also be emailed to: erica@lfd.dentist

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Patient's Name/ DOB
(Please include all family members' names)

Signature of Patient (Guardian)