

Dr. Jared Stubbs & Dr. Lisa Daft

P.O. Box 520
Seekonk, MA 02771

508-336-7260
fax- 508-336-5970

Request for copy of records

Requesting records from: Doctor _____

Address _____

Phone _____

You are hereby requested and authorized to release all Protected Health Information in the form(s) of Records, Radiographs, and Treatment notes or other information concerning the patient(s) listed below:

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Please forward records to: Dr. Jared Stubbs & Dr. Lisa Daft

PO Box 520

Seekonk, MA 02771

508-336-7260

Fax: 508-336-5970

Date: _____ Patient/Guardian _____

(Signature)

Dr. Jared Stubbs & Dr. Lisa Daft

P.O. Box 520
Seekonk, MA 02771

508-336-7260
fax- 508-336-5970

Request for Transfer of Copy of Dental Records

Requesting records from: **Dr. Jared Stubbs & Dr. Lisa Daft**
PO Box 520 Taunton Ave
Seekonk, MA 02771

You are hereby requested and authorized to release all Protected Health Information in the form(s) of Records, Radiographs, and Treatment notes or other information concerning the patient(s) listed below:

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Reason for Transfer (optional) _____

Please forward records to: Name _____

Address _____

Phone _____

Date: _____ Patient/Guardian _____

(Signature)