Steven Sepe, DDS
1686 Centre Street
West Roxbury, MA 02132
Phone: 617-323-8970
Email: drsepe@speakeasy.net

Today's Date: _____

The purpose of this letter is to request copies of my dental records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

I am giving permission to **release / transfer my entire Dental Record: which include x-rays, periodontal charting and written treatment notes, via facsimile, email or mail:**

Name:_____DOB_____ to:

Steven Sepe, DDS
1686 Centre Street
West Roxbury, MA 02132
Phone: 617-323-8970
Fax: 617-323-0410
Email: drsepe@speakeasy.net

Please call me to confirm receipt of this document at _____ and please call Dr. Sepe at 617-323-8970

I look forward to Dr. Sepe's office receiving the above records within 15 days.

Thank you for your service.

Sincerely,

_____
Name