11416 Shelbyville Road
Louisville, KY 40243
T: 502.245.8442 F: 502.245.8440
foundationsdentistry@gmail.com

The following patient has requested that their records be released to our office. Please fax, email, or mail at your earliest convenience. Thank you!

Patient: _____
Date of Birth: _____
Patient's Address:

_____
_____
_____
_____

I hereby authorize_____ to release my dental records to the above practitioner.

_____
_____
Signature **Date**