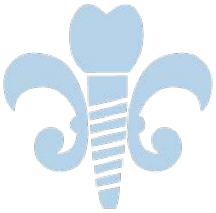

LOUISVILLE DENTAL IMPLANTS

904 Lily Creek Rd.
Suite 101
Louisville, KY 40243
Phone: 502-467-5268
Fax: 502-409-4309
Email: info@louisvilledentalimplants.com

Medical Record Release Request

Date:
Please send records to our office email.

Patient's Name: _____

Patient's Date of Birth: _____

I authorize the release of dental records and/or medical records relevant to dental treatment, or copies of such, and request that they be sent to the above dental office.

Signature:

_____
(patient/parent, guardian)

Printed Name: _____