

Fairbourn Family Dentistry
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Shelbyville, KY 40065
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Records Release Request

Name of patient:

Patient DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional minor family members to be included:

Name: _____

DOB: _____

Name: _____

DOB: _____

Name: _____

DOB: _____

Previous Dentist/Dental Office: _____

email: _____ phone: _____

Fax: _____

I, (print patient or guardian name)

hereby authorize the release of dental records or knowledge concerning the dental health of the patients listed above. I further request that these records be transferred to:

_____ Address: _____

Email: fairbourndentistry@yahoo.com

Signed (patient or guardian)

_____ Date _____

