
## Dental Records Release Form

I hereby authorize release of my X-rays and entire record information to Smile Academy of Kentucky on Dixie.

Patient Name: _____ Patient DOB: _____

Other family members to transfer:

Patient Name: _____ Patient DOB: _____
Patient Name: _____ Patient DOB: _____
Patient Name: _____ Patient DOB: _____
Patient Name: _____ Patient DOB: _____
Patient Name: _____ Patient DOB: _____

Dentist's Name (Print): _____

Dentist's Address (Print): _____

_____

Dentist's Phone Number: _____

If records are digital, please email to: frontoffice@smileacademyofkentucky.com

Or mail to: Smile Academy of Kentucky
6801 Dixie Highway
Suite 128
Louisville, Ky. 40258

Patient's Signature_____ Date: _____