The Center for Aesthetic & Implant Dentistry

DAVID C. JONES, DMD
12010 Shelbyville Rd.
Louisville, Kentucky 40243
tel 502-589-4671 / fax 502-589-6584
SmileLouisville.com

Medical Records Release Form

I _____ authorize the release of information concerning dental care history for the following patient(s) to the office below:

Patient(s) First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Date(s) of Birth _____

Transfer Records to:

Dental Office Name: David C. Jones, D.M.D.

Address: 12010 Shelbyville Rd. Ste. 100

City, State, Zip: Louisville, KY 40243

Telephone: (502) 589-4671

E-mail Address: SmileLouisville@yahoo.com

Patient or Gaurdian Signature _____ Date _____

Office Signature _____ Date of Transfer _____

**Please fax or mail this form to David C. Jones, D.M.D.*