

Dental Wellness of Lexington
527 Wellington Way, Suite 120
Lexington, KY 40503

Phone: 859-223-4644
Fax: 859-224-8466

Records Release Form

Date: _____

Patient: _____

Date of Birth: _____

Please forward all of my current x-rays and other dental records to:

Dental Wellness of Lexington
527 Wellington Way, Suite 120
Lexington, KY 40503

OR

E-mail to:

mandy@lexingtodental.com

Thank You,

Patient/Guardian Signature

Dentist: _____ Phone: _____ Fax: _____