RECORDS RELEASE REQUEST FORM
BEECHMONT FAMILY DENTAL

4825 S. 3rd St
Louisville, KY 40214
Office: 502-366-6362
Fax: 502-368-8600
office@bfddent.com

Morgan Menard DMD Casey Crowdis DMD Erin Wilson DMD

I request a copy of my medical record as detailed below

- Complete record held by this office
- Record for the period _____ through _____
- A specific portion/section of the record as follows:

  _____
  _____
  _____
  _____
  _____

Patient Name (as shown on records): _____
Patient Signature: _____
Date of Birth: _____
Relationship to patient: _____
Date of request: _____

**Please allow 10 business days to process this request*

If the patient is a minor, name and signature of parent or legal guardian making the request: _____

Records will be picked up in office by: _____
Please mail records to: _____