



Where ordinary smiles become **Extraordinary.**

I, _____ do hereby authorize Dr. _____
(Pt Name) (Previous Dentist)

to release my dental records and diagnostic xrays to Dr. Philip Cornette III, DMD.

Pt. Name: _____

Pt. Signature: _____ Date: _____

Witness: _____

Please send records to:
Aesthetic Dental Center of Kentucky
347 W. Lincoln Tr. #1
Radcliff, Ky. 40160
270-351-3505