Tina P. Moses, DMD, PC

Pediatric Dentistry

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RECORDS RELEASE REQUEST

DATE_____

I authorize the release of dental and medical records relevant to dental treatment, or copies of such, and request that they are transferred to:

NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

EMAIL_____

_____	_____
PRINT NAME OF PATIENT	DATE OF BIRTH
_____	_____
PRINT NAME OF PATIENT	DATE OF BIRTH
_____	_____
PRINT NAME OF PATIENT	DATE OF BIRTH

_____	_____
PRINT NAME OF PARENT/GUARDIAN	PARENT/GUARDIAN SIGNATURE

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