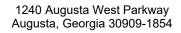


## Tina P. Moses, DMD, PC

## **Pediatric Dentistry**





## RECORDS RELEASE REQUEST

DATE	<u>-</u>	
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		
		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/GUARDI	AN	PARENT/GUARDIAN SIGNATURE
	<del></del> ·	