DONNA THOMAS MOSES, D.M.D., P.C.
Practice Limited to Periodontics and Dental Implants

Release of Medical/Dental Records

Dear patient,

In the future, our office may need to request medical records from your physician/s. Please complete the highlighted areas of this form so that we may have it on file should the need arise. Thank you!

Dear ____

The following individual has asked us to request that his/her medical records be released and forwarded to the address listed below:

_______________________________________ _________________________

Patient's Name Date of Birth

Forward records to: Dr. Donna Thomas Moses
530 Newnan Street
Carrollton, GA 30117
770.832.0089 770.830.9531 Fax

Please include the following information:

_______ Copy of complete medical records

_______ Copy of complete dental records

_______ Lab results: ____

_______ Radiographs

_______ Other: ____

I hereby authorize the release of all medial records indicated to the address listed above. I wish for them to be forwarded as soon as possible.

____ _________________________

Patient or Guardian's Signature Date

____ _________________________

Physician's Name Phone Number

____ _________________________

Address (city, state, zip code) Fax Number