



DONNA THOMAS MOSES, D.M.D., P.C.

Practice Limited to Periodontics and Dental Implants

Release of Medical/Dental Records

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, Georgia 30117
(770) 832-0089 Phone (770) 830-9531 Fax

Please be sure to include the following information:

- _____ Copy of complete medical record(s)
- _____ Copy of complete dental record(s)
- _____ 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 Signature _____ Date

_____ Physician's Name _____ Phone Number

_____ Address (city, state, zip code) _____ Fax Number