RECORDS RELEASE REQUEST FOR TREATMENT PURPOSES

DATE: ______________________________

REQUEST FOR RECORDS OF: _______________________________________

TO: ____

ADDRESS: ____

CITY: ____ STATE: _____________

ZIP: ________________

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

AMY T. MOUBRY, DDS, PA

~ Family Dentistry ~

530 NW Broad Street ~ Southern Pines, NC 28387

Telephone: (910) 692-0703

____ ________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient:____