Records Release Request

In order to release your records all of the information below must be complete and correct.

Date: _____

Patient Name: _____ Date of Birth: _____

To/From: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone: _____ Email: _____

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/from:

Amy T. Moubry, DDS, PA

Moubry Family Dentistry

530 NW Broad Street, Southern Pines, NC 28387

Phone: 910-692-0703 Fax: 910-692-0709

Email: frontdesk@moubryfamilydentistry.com

_____ _____

Signature of Patient, Parent or Guardian or Personal Representative Date:

_____

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

Relationship to Patient: _____