**Moore Family & Cosmetic Dentistry**
*William D. Moore Jr., D.M.D.*
104 East North Street
Greensboro, Georgia 30642
706-453-2351
Fax: 706-453-4714
williamdmoorejrdmd@gmail.com

I, _____authorize _____ to release copies of my

(Patient/Legal Guardian Name) (Previous/Current Dental Office)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Phone #) (Fax #)

dental records with respect to any dental care and treatment to:

Moore Family & Cosmetic Dentistry
104 East North ST
Greensboro, GA 30642
706-453-2351
FAX 706-453-4717
williamdmoorejrdmd@gmail.com

I understand that the specific type of information to be disclosed may include a detailed report of examinations, findings, treatments, prognosis, and/or x-rays, which pertain to me.
I hereby release Moore Family & Cosmetic Dentistry from all legal responsibility or legal liability that may arise from the release of such information. I understand that I may revoke this consent at any time, except that the action has been taken in reliance upon it and that in any event this consent shall expire ninety (90) days after the date below.

A reproduced copy of this authorization shall be as valid as the original.

Patient Printed Name:_____ DOB: _____

Patient Signature:_____ DATE:_____

(Patient/Legal Guardian)

Relationship to Patient:_____

Patient Address:_____