Moore Family & Cosmetic Dentistry
William D. Moore Jr., D.M.D.
1961 South Main Street
Greensboro, Ga 30642
706-453-2351
office@dentistrybymoore.com

I,_____authorize_____to release copies of
(Patient/Legal Guardian Name) (Previous/Current Dental Office)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Phone#) (Fax #)

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

Moore Family & Cosmetic Dentistry
1961 South Main Street
Greensboro, Ga 30642
706-453-2351
FAX 706-453-4714
office@dentistrybymoore.com

I understand that the specific type of information to be disclosed may include a detailed report of examinations, findings, treatment, 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:_____