Timothy J. Moore, DDS, P.C. & Marisa S. Fox, DMD

4700 So. 6th Street
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Phone: (541)273-6100
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Authorization for Disclosure of Patient Information

Patient Name:____

Patient's Date of Birth:___________________ Phone number:________________________

Other family members to transfer records:_______________________________________

Previous Dentist or Practice Name:____

Address:____

City/State/Zip:____

Phone number:____________________   Fax number:________________________

Please forward any of the following records: x-rays, periodontal charting, chart notes, photographs

I hereby give my permission to have my dental records released to Dr. Timothy J. Moore, DDS, P.C. and Dr. Marisa S. Fox, DMD

Signature of Patient or Patient's Personal Representative:

____ Date:__________________

Print Name:_________________________   Relationship to Patient:________________

Please mail, fax or e-mail records to:
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