MID-VALLEY
DENTAL ASSOCIATES

Brian Tidwell, DDS

AUTHORIZATION TO RELEASE DENTAL RECORDS

Printed Patient Name: _____

Patient Birthdate: _____

I hereby authorize _____ to release copies of my dental records including radiographs to **Mid-Valley Dental Associates**

2300 NW Kings Blvd.
Corvallis, OR 97330

Phone: (541) 754-2214 | Fax: (541) 754-6631

corvallis@midvalleydentaloregon.com

_____ _____
Signature of patient or patient's representative Date