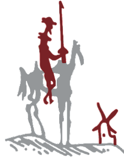

MID-VALLEY
DENTAL ASSOCIATES

Taylor C. Bennion, DMD

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**

2811 Main Street
Philomath, OR 97370

Phone: (541) 929-5227 | Fax: (541) 929-7649

philomath@midvalleydentaloregon.com

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Signature of patient or patient's representative   Date