MID-VALLEY
DENTAL ASSOCIATES

Steven Deming, 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**

197 SE Washington Street
Dallas, OR 97338

Phone: (503) 623-2389 | Fax: (503) 623-2099

dallas@midvalleydentaloregon.com

_____ _____
Signature of patient or patient's representative Date