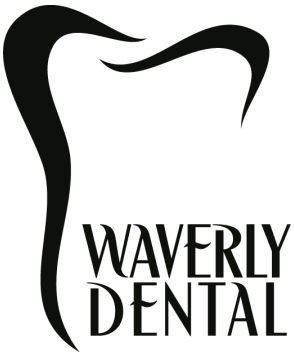

Alexay Tamas, DMD

AUTHORIZATION TO RELEASE DENTAL RECORDS

Printed Patient Name: _____

Patient Birthdate: _____

I hereby authorize _____ to release copies of my dental records including radiographs to **Waverly Dental**

721 Waverly Dr. SE

Albany, OR 97322

Phone: (541) 928-8434 | Fax: (541) 928-2756

office@waverlydentalalbany.com

_____ _____

Signature of patient or patient's representative Date