Alexay Tamas, DMD

721 Waverly Dr. SE
Albany, OR 97322
(541) 928-8434

AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient Name:_____

DOB: _____

I hereby authorize _____ to release copies of my

dental records including radiographs to:

Waverly Dental
721 Waverly Dr. SE
Albany, OR 97322

OR

Email to: waverlydentalalbany@gmail.com

Signature: _____ Date: _____