MID-VALLEY
DENTAL ASSOCIATES

**Geoffrey A. Berg, DMD**
**Daniel H. Reynolds, 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**

2825 Willetta St. SW
Albany, OR 97321

Phone: (541) 928-2301 | Fax: (541) 928-8493

albany@midvalleydentaloregon.com

_____ _____
Signature of patient or patient's representative Date