Geoffrey Berg, DMD

AUTHORIZATION TO RELEASE DENTAL RECORDS

Printed Patient Name: _____

Patient Birthdate: _____

I hereby authorize _____ to release copies of my dental records including radiographs to **Alder Dental Group.**

7110 SW Hazel Fern Road, Suite #240
Tigard, OR 97224

Phone: (503) 431-3200 | Fax: (503) 431-3210

office@alderdentaltigard.com

_____ _____

Signature of patient or patient's representative Date