Tom Laster, DDS

I, _____, authorize the office of: _____

(patient) (former dentist)

To release x-rays, periodontal charting, chart notes, and any other information they feel may be helpful to:

Dr. Tom Laster

2444 NW Professional Dr

Corvallis, OR 97330

info@tomlasterdds.com

Patient's signature: _____

Date:_____

***If a fee is required for this service, please invoice Dr. Laster's office on behalf of the patient. ***