Tom Laster, DDS

I authorize the office of: _____ to release

(previous doctor's office)

chart notes, x-rays, periodontal charting, and any other information they feel may be helpful for patient: _____ to the office of:

Dr. Tom Laster

2444 NW Professional Dr

Corvallis, OR 97330

info@tomlasterdds.com

Patient/guardian/PoA name: _____

Patient/guardian/PoA signature: _____

Date: _____

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