RECORDS RELEASE REQUEST

Patient Name:_____ Date of Birth: _____

I hereby request and authorize _____ (prior dentist)

to release a copy of my dental records to:

Dr. Brenden Davis, DMD, MPH

Northwest Oral Health Outreach
1206 N. Dolarway Rd, #208
Ellensburg, WA 98926

Phone #: 509-925-7600
Fax #: 855-426-9646
Email: info@nwoho.com

Please send the following information (check applicable lines):

___ All health care information in my dental record including x-rays

___ Specific records related to the following condition: _____

___ Specifically exclude: _____

_____

I also give my express consent to release information relating to sexually transmitted disease, HIV, mental health, and/or drug/alcohol abuse, pursuant to Washington Law RCW 70.24 ET.SEQ, unless specifically excluded above.

Patient or Legal Authorized Signature: _____ Date: _____

Relationship to patient (if under 18 years of age): _____