Northwest Oral Health
Toll free: 855-426-9646
www.nwoho.com
info@nwoho.com

Patient Name:_____ Date of Birth: _____

I hereby authorize and request you to release a copy of my dental records to:

Dr. Brenden Davis, DMD, MPH

Select an office location:

	KENNEWICK OFFICE	or	ELLENSBURG OFFICE
☐	Northwest Oral Health 910 S Columbia Center Blvd Ste D Kennewick, WA 99336-9560 Phone #: 509-557-7999 Fax #: 509-619-0200 Email: records@nwoho.com	☐	Northwest Oral Health Outreach 1206 N. Dolarway Rd, #208 Ellensburg, WA 98926 Phone #: 509-925-7600 Fax #: 509-925-9646 Email: reception@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/Legal Authorized Signature: _____ Date: _____

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