# KELLY TAYLOR, DMD
# 860 SOUTH SECOND AVE., STE A
# WALLA WALLA, WA 99362
# (509)529-2000

## RELEASE OF RECORDS

I,_____, hereby authorize
Patient or Guardian name

_____to disclose and provide copies

Of any and all clinical treatment records and information concerning my care, which is in the possession of this person or entity, to

KELLY TAYLOR, DMD
860 SOUTH SECOND AVE, STE. A
WALLA WALLA, WA 99362

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment records, referral and consultation recommendations and reports, and other related materials.

I expressly release the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

Signed:

_____Date:_____