Smile Esthetics
SCOTTSDALE

Patient Records Release

Dear Dr. _____,

We would like to request all clinical notes and x-rays for _____
to be sent to our office. (patient name)

Authorization to release Medical Information

I authorize the release of all my medical files and x-rays from Dr. _____ to Smile Esthetics Scottsdale

via email:
smileesthetics@gmail.com

or via mail:
Smile Esthetics Scottsdale
11390 E Via Linda Ste 104
Scottsdale, AZ 85259-4075

_____ _____
Patient Signature (Custodian Signature if Minor) Date

Smile Esthetics Scottsdale
11390 E Via Linda Ste 104 Scottsdale, AZ 85259-4075
P: 480.867.1727 F: 480.867.1791
smileestheticsscottsdale.com