



Records Release Authorization

I _____ hereby request and authorize the release of my clinical records and radiographs concerning my past dental treatment at your office to:

Grayhawk Prosthodontics, P.C.
7930 E. Thompson Peak Pkwy. STE. 102
Scottsdale, AZ 85255

Patient(s) Name(s):

_____	Date of Birth: _____
_____	Date of Birth: _____
_____	Date of Birth: _____
_____	Date of Birth: _____

Signature: _____ **Date:** _____