Grayhawk Prosthodontics, P.C.

Records Release Authorization

I _____ hereby grant Grayhawk Prosthodontics permission to obtain all my records from those whom are listed below:

Doctor/Office

Office Name: _____ Dr. Name: _____

Phone Number: _____

Office Name: _____ Dr. Name: _____

Phone Number: _____

Printed Name: _____ Signature: _____

Date: _____