



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*