SCOTTSDALE ★ PROSTHODONTISTS

AESTHETIC AND RECONSTRUCTIVE DENTAL SPECIALISTS

Authorization to Transfer Records

I hereby request my dental records, including but not limited to diagnostic reports, x-rays and correspondence related to my dental care, be provided to Scottsdale Prosthodontist.

If the records and x-rays are in digital form, please email them to:

mgibbonsdmd@gmail.com

If they are not digital and cannot be emailed, please mail them to the following address:

Scottsdale Prosthodontist

11111 N. Scottsdale Road, Suite 220

Scottsdale, AZ 85254

Patient Name:_____ Patient DOB: _____

This authorization shall remain in effect until written documentation is provided to the office.

_____ _____

Print Name Date

_____ _____

Signature Relationship if other than self