



Patient Authority to Release Records

Date: _____

I, _____, consent to the release of my dental diagnostic radiographs and photos from:

Spodak Dental Group
3911 West Atlantic Avenue
Delray Beach, FL33445
inform@spodakdental.com

If applicable, diagnostic models will be released. _____ (Initials)

And authorize that my records be released to:

Patient Name: _____

Patient Email Address: _____

Patient Phone Number: _____

Patient Signature: _____

Guardian Signature (If Applicable): _____

@spodakdental



www.spodakdental.com

Call/Text: 561.303.2413

Fax: 561.403.0962