Patient Authority to Release Records

Date: ____________________

I, _______________________, consent to the release of my dental diagnostic radiographs

and photos from _____________________________ (Dental Office Name), at the following

addresses (Email and/or Physical):

____

____,

And authorize that my records be released to:

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

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

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