



## 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  
hello@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](http://www.spodakdental.com)

Call/Text: 561.303.2413

Fax: 561.403.0962