P·B·P
DENTAL ASSOCIATES

Authorization for Release of Dental Radiographs and/or Records

I, _____ authorize _____
(Patient Name) (Practice/Doctor's name)
to release any necessary radiographs and/or records, past, present, or future to PBP Dental Associates.

Please email to:

info@prosdent.com

Or mail to:

PBP Dental Associates
1401 Forum Way, Suite 800
West Palm Beach, FL 33401

Signed _____ Date _____