



PALM BEACH
PROSTHODONTICS

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Authorization for Release of Dental Radiographs

I, _____ authorize _____
(Patient name) (Practice/Doctor's name)

to release any necessary radiographs past, present or future to Palm Beach Prosthodontics.

Signed: _____ Date: _____

Please email if possible to:

Info@prosdent.com

Or mail to:

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West Palm Beach, Florida 33401