



Dr. Tiffany K. Shields
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Dental X-Ray Release Form

I, (printed patient or guardian name) _____, hereby authorize the doctor and team to release the current x-rays they have on file (select one):

___1. Different Provider:

Name of Dental Practice:

Telephone Number:

Email Address:

___2. Email directly to me at:

___3. Email to our office at records@smilesbyshields.com

X

Date:

Signature