Dr. Tiffany K. Shields, D.M.D.

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Jacksonville, Fl 32217

Dental X-Ray Release Form

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

_____1. Given directly to me

_____2. E-Mail to:

Name of Dental Practice:

Address:

Telephone Number:

E-Mail Address:

_____3. Given to a guardian (if patient is a minor)

X Date

Signature