Dr. Tiffany K. Shields
Dr. Paola Rodriguez
3940 San Jose Park Drive
Jacksonville, FL 3317

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