



RELEASE OF PATIENT X-RAY AND RECORDS

Date _____

I _____ hereby authorize
Patient Name

_____ to release my dental records and x-rays to:
Previous Dentist

trinitydentist@verizon.net

Robert P. Wolfenden D.D.S
Shawn J. Douglas D.D.S.
Valentina Espinosa D.M.D
1821 Wellness Lane
Trinity FL 34655
(727)372-3200

Patient Signature

Print Name

Patient Address

Patient Date of birth

1821 Wellness Lane, Bldg. #3 Trinity, FL 34655
(727)372-3200
Fax (727)372-0505