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ROBERT A. ZAMBROWSKI, D.M.D., M.A.G.D.
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RELEASE OF INFORMATION

I, ____________________________, do herby authorize Robert A. Zambrowski, D.M.D., M.AG.D., and Michael A. Zambrowski, D.D.S. to obtain any X-rays and pertinent information from my previous dentist.

Previous Dentist: ____

Mailing Address: ____

City, State, Zip: ____

Phone Number: ____

Fax Number: ____

Your Name: ____

Date of Birth: ____

Signature: ____

Date: ____________________________

Mailed: ________ Faxed: ________