Zambrowski General Dentistry
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Release of Dental Records

I, _____, do hereby 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 Code:

Phone Number:

Patient Name:

Date of Birth:

Today's Date:

Patient or Guardian Signature:

_____