

Zambrowski General Dentistry  
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Release of Dental Records

I, \_\_\_\_\_, do hereby authorize Robert A. Zambrowski, D.M.D., M.A.G.D, and Michael A. Zambrowski, D.D.S to release copies of my dental records, to include X-Rays and pertinent information to the dental provider(s) listed below.

**Dentist Transferring To:**

**Mailing Address:**

**City, State, Zip Code:**

**Phone Number:**

**Patient Name:**

**Date of Birth:**

**Today's Date:**

**Patient or Guardian Signature:**

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