

# Paul J. Kramer & James K. Kramer

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**Paul J. Kramer, D.M.D**  
**James K. Kramer, D.M.D., P.A.**

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## Request for Release of Previous Dentist Information

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Date:

I, (your name) \_\_\_\_\_,

hereby authorize (previous dentist) \_\_\_\_\_

(phone number) \_\_\_\_\_

to release and email information related to my health history, treatment status, copies of my X-rays, health records, and any test results to:

\_\_\_\_\_

\_\_\_\_\_

Email address:

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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Response Date: \_\_\_\_\_