DBDentistry
111 N. Wabash Ave., Suite 1921
Chicago, Illinois 60602
Ph: 312-332-4424
Fax: 312-332-4423

I, _____, DOB_____ am authorizing
Please print name here
you and requesting that all of my dental records, including, but not limited to, treatment records, medical information and radiographs be released to:

Sunaina S. Sahgal DDS
30 N. Michigan Ave.
Chicago, IL. 60602

Signature: _____

Phone Number: _____