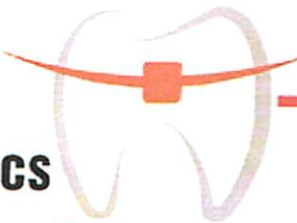


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Release of Financial/Treatment Information

I, _____, hereby authorize access to
any financial/treatment information regarding

to the person(s) listed below:

- | | |
|------------------|-------|
| 1. _____
Name | _____ |
| 2. _____
Name | _____ |
| 3. _____
Name | _____ |
- Relationship to Patient
- Relationship to Patient
- Relationship to Patient

Responsible Party Signature

Date



American Association of Orthodontists