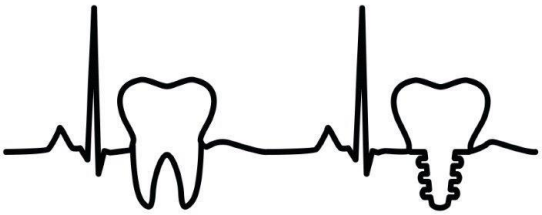

MARIANNE MORELLI, D.M.D.

BROOKFIELD FAMILY DENTISTRY, LLC

Date: _____

Dear Dr. _____

Print Name: I, _____, give my permission for you to release my dental records and most recent radiographs to:

Dr. Marianne Morelli

834 Federal Road, Suite A

Brookfield, CT 06804

Office: (203) 775-6167

Fax: (203) 775-6169

office@drmorelli.com

Signature: _____