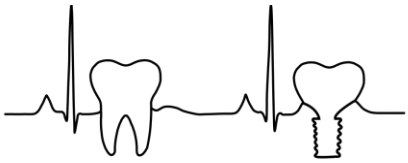

MARIANNE MORELLI, D.M.D.

BROOKFIELD FAMILY DENTISTRY, LLC

Date: _____

Dear Dr. _____
First Name Last Name Practice Location

Print Name: I, _____, give my permission for you to release my dental radiographs, implant specifications and clinical notes to:

Dr. Marianne Morelli

834 Federal Road, Suite A

Brookfield, CT 06804

Office: (203) 775-6167

Fax: (203) 775-6169

office@drmorelli.com

Signature: _____

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834 FEDERAL ROAD, BROOKFIELD, CT 06804
EMAIL: OFFICE@DRMORELLI.COM
OFFICE: (203)775-6167
FAX: (203)775-6169