



Authorization to Release Information

I authorize the release of the following information:

- Treatment plan and progress
- Financial information
- Appointment information

To:

(Name of other party)

For:

(Name of patient)

Signed

(Responsible party)

Date

Judith G. Demro, D.D.S., M.S. *Specialist in Orthodontics & Dentofacial Orthopedics*

655 South Illinois Avenue ■ Mason City, Iowa 50401 ■ (641) 424-3375