



*Garry N. Steen, D.M.D.*

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Date:

To Dr. Gary N. Steen,

I, \_\_\_\_\_ give my permission to \_\_\_\_\_  
(relationship to the patient \_\_\_\_\_) to discuss any dental treatment,  
financial arrangements and scheduling with the Dr. Steen's Office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name