REMOVAL OF ORTHODONTIC APPLIANCES RELEASE

Patient's Name: _____ Date: _____

Date of Birth: _____

This is to certify that I, _____as the _____
Relationship

of _____requests the removal of orthodontic appliances
Patient's Name

and the termination of treatment. I have been informed that treatment has not been completed and that the Volusia County Health Department Dental Staff recommends the continuation of treatment in order to obtain the best results.

I hereby release the Volusia County health Department and its staff from any responsibility for all consequences caused by's treatment being terminated.

_____
Signature

_____
Witness No. 1

_____
Witness No. 2