RETURN FAX: 1-855-522-2212

Account information Fax Release & Request **Office ID: _____________ Date: ______________**

I authorize and request that upon receipt of this form, and from this day forward upon request of Auhtorized Contacts, instream Canada Inc. may transmit my password and certificate installation instructions to the office fax number currenbtly on file that pertains to the Office ID listed above. I also release instream Canada Inc. of any security liability and acknowledge that this means of transport may not be secure and the personal information contained in this (these) communication (s) may ultimately be viewed by a third party or lost in transport.

The above release and request apply to and are authorized by the following dentists:

Dentist Name: ________________________________ Dentist Signature: ____________________________
NO STAMPS

Dentist Name: ________________________________ Dentist Signature: ____________________________
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Dentist Name: ________________________________ Dentist Signature: ____________________________
NO STAMPS

Dentist Name: ________________________________ Dentist Signature: ____________________________
NO STAMPS

"The information in this communication, including any attached documentation, is intended only for the person or entity to which it is addressed, and may contain confidential, personal, and/or privileged information. Any unauthorized disclosure, copying, or taking action on the contents is strictly prohibited. If you have received this message in error, please contact us immediately so we may correct our records. Thank you."