Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment

I, _____ and/or _____
Name of Patient (Parent or Guardian if Minor) Name of Insured

hereby authorize the office of _____

to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above.

I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

This "Authorization" will be valid from this date and shall expire in one year.
A photocopy of this document may act as an original.

_____
Signature of Insured

_____
Witnessed By

_____
Signature of Patient (Parent or Guardian if Minor)

Today's Date _____

Expiration Date_____

ITEM#SOF104