YOUR SIGNATURE IS NECESSARY FOR US TO:

1. PROCESS ALL INSURANCE CLAIMS;

2. ENSURE PAYMENT FOR SERVICES PROVIDED

3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS

4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to DOCTOR/PRACTICE NAME. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature ____

Patient Full Name (printed) ___________________________________

Parent Signature (if minor) ___________________________________

Witness ____

Date Signed ____

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