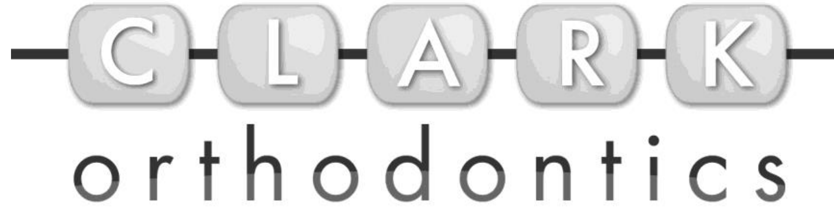

PATIENT AUTHORIZED SIGNATURE FORM

The undersigned hereby authorizes the release of any information relating to all insurance claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit insurance claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every insurance claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular insurance claim.

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Authorized Signature of Covered Person/Employee

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Date