MEDICAL- DENTAL INSURANCE AUTHORIZATION

SIGNATURE ON FILE

- ❑ I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS
- ❑ I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE CARRIERS
- ❑ I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL
- ❑ I AUTHORIZED MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN
- ❑ PAYMENT FROM MY INSURANCE CARRIER
- ❑ I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR
- ❑ I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

NAME: _____ DATE OF BIRTH:_____
(PLEASE PRINT)

SOC SEC # _____

SIGNATURE :_____ DATE: _____

Relationship to patient (if signed by a personal representative of patient): _____