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 Integrated Dental Care, LLC 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. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

_____ _____
Signature of Insured Witnessed by

_____ _____
Signature of Patient (Parent or Guardian) Date