
ATTENDING D.D.S. NAME

is authorized to provide any insurance company(s), claim administrator (s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

DATE

SIGNATURE ON FILE