Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment

I, ____ and/or ____

(Name of patient (legal guardian of minor) **(Name of person carrying the insurance)**

Hereby authorize the office of Kiran Mistry, DD to affix my name to any and all claims or documents as related to any and all dental health benefits due me and my dependents through my employment or other organization:

____

(Place of employment or other organization offering the insurance)

I hereby authorize payment of dental benefits, otherwise payable to me, directly to the office listed above. I understand I am responsible for all charges for dental services and materials not paid by my dental plan. To the extent permitted under applicable low, I authorize release of any information relating to the claim. This authorization may be updated on the lines provided below. A photocopy of this may act as an original.

_________________________________ _____________________________________

(Signature of Insured) **(Witnessed By)**

_________________________________ Today's Date ______________

(Signature of Patient or legal guardian of minor)

Update Signature ___________________________ Update Date ______________________

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