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Patient Release Form

I, the undersigned, hereby authorize the release of x-rays and other information for referrals which may be needed for treatment as well as information relating to all claims for benefits submitted on my behalf and/or on behalf of my dependents. Further, I expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered, or to be rendered, without obtaining my signature on each and every claim to be submitted for me and/or my dependents; and, that I will be bound by this signature as though I, the undersigned, had personally signed the particular claim.

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Patient Name

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Authorized Signature of Covered Person/Guardian Date