

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)

authorize the office of Jeffrey A. Oras D.M.D. 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. I have reviewed the treatment plan & fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I authorize release of any information relating to the claim.

This "Authorization" will be valid from this date and shall expire in one year.
A photocopy of this document may act as an original.

Signature of insured

Witnessed by

Signature of Patient (Parent or Guardian if Minor)

Today's Date