AUTHORIZATION FOR SIGNATURE ON FILE
RELEASE OF INFORMATION/FINANCIAL RESPONSIBILITY
AUTHORIZATION FOR PAYMENT

I, _____ and/or _____
Name of Patient (Parent/Guardian) Name of Insured

Hereby authorize the office of Edward W. Urbina, D.D.S. 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 and 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. To the extent permitted under applicable law. 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

_____
Signature of Patient (Parent/Guardian)

_____
Witnessed By

_____
Today's Date

_____
Expiration Date