FOR INSURANCE PURPOSES:

PLEASE SIGN AND RETURN IMMEDIATELY

Patient's name: _____

Employee name: _____

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

AUTHORIZATION TO PAY BENEFITS TO DENTIST – I hereby authorize payment directly to the below-named Dentist of the Dental Benefits otherwise payable to me.

Great Smiles Orthodontic Specialists

Ryan J. Haldeman, DDS, MS, PA • Stephanie S. Chambers, DDS, MS, MSD

SIGNED: _____ DATE: _____

Thank you for your cooperation.