

**SIGNATURE RELEASE STATEMENT**

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**YOUR SIGNATURE IS NECESSARY FOR US TO:**

- 1. PROCESS ALL INSURANCE CLAIMS;**
- 2. ENSURE PAYMENT FOR SERVICES PROVIDED**
- 3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS**
- 4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to DOCTOR/PRACTICE NAME. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature \_\_\_\_\_

Patient Full Name (printed) \_\_\_\_\_

Parent Signature (if minor) \_\_\_\_\_

Witness \_\_\_\_\_

Date Signed \_\_\_\_\_