ARDEN PREMIER
DENTISTRY
ardenpremierdentistry.com

Release of Information for Insurance Purposes

Patient 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.

Arden Premier Dentistry

Jessica O. Planer, DDS

Signed: ____**Date**:________________

(Patient, Parent or Guardians)