AUTHORIZATION AND RELEASE

Please Read and Sign Below

I certify that the information I have provided on this form is complete and accurate. I understand that it is my responsibility to notify this office of any changes or updates in medical status. I authorize the dentist to release any information, including diagnosis, treatment plans/records, and x-rays to thirds party payors and/or health practitioners. In consideration to treatment and services rendered to me or my dependants in this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its Financial Policy.

SignatureDate

_____ _____

Signature Date