

## SIGNATURE ON FILE

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on the document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, \_\_\_\_\_, hereby authorize  
(Patient Name)

\_\_\_\_\_, to pay and hereby  
(Insurance Company)

assign directly to *Arizona Periodontal Group* all benefits, if any, otherwise payable to me for services as described on the attached forms. I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to *Arizona Periodontal Group*. Authorization is hereby given to release all information necessary to the payment of said benefits.

\_\_\_\_\_  
(Authorized Signature of Covered Person/Employee)

\_\_\_\_\_  
(Date)

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## Release of Information

I, \_\_\_\_\_, hereby authorize Arizona Periodontal Group  
(patient name)  
to disclose any and all clinical treatment records and information concerning my care to  
any of the persons listed below.

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relation to Patient)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relation to Patient)

\_\_\_\_\_  
(Authorized Signature of Patient)

\_\_\_\_\_  
(Date)