BIRCH
FAMILY DENTAL
Family & Cosmetic Dentistry

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER.

I, the responsible party listed above, hereby authorize this office, including its employees, to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my child's medical records to any other entity, including, but not limited to specialty hospitals, physicians, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of any records necessary to assist in the reimbursement of insurance benefits to which I may be entitled.

I, authorize the office and its employees to release medical records which are needed in ordered to provide the patient with the most appropriate medical care.

I, authorize and request the payment of my third party or insurance company benefits be made directly to this office for any services or treatments given to the patient. The signature provided below shall suffice for all services or treatments given to the patient.

First: _____ Last: _____ _____

Printed Name Signature

_____

Date