Medical Information Release

Patient Name: _____ Insured Name:_____

Patient DOB:_____ Insured DOB:_____

If Metlife or Delta Dental SSN of Insured is required: _____

Your Signature is necessary for us to:

- PROCESS ALL INSURANCE CLAIMS
- ENSURE PAYMENT FOR SERVICES RENDERED
- RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
- RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES WHEN NECESSARY FOR YOUR TREATMENT.
- PROVIDE EXCELLENT DIAGNOSTIC AND PREVENTIVE CARE

I hereby authorize the release of all medical information necessary to process my claims and I authorize the 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.
Any payments made to the patient from the insurance company should be submitted to the office to cover the treatment rendered in the practice.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled to Dr._____. This assignment will remain in effect until revoked by me in writing. Photocopy of this assignment to be considered as valid as the original.

Patient or Guardian Signature: _____

Date: _____