FAMILY DENTAL

AUTHORIZATION FORM

Date: _____
RE: _____

I, _____hereby grant authority to _____, my_____, to obtain information on all files necessary pertaining to any and all claims under my responsibility from K&E Family Dental and its affiliates.
This authorization is effective immediately and can be revoked in writing at any time. A photocopy of this authorization is as valid as the original. I further authorize the above named person to schedule appointments in my absence.

Thank you.

Patient Name_____

Patient Signature_____