Potach & Mitchell Dental Clinic

607 1st Dr. NW, Austin MN 55912

INSURANCE AUTHORIZATION- SIGNATURE ON FILE

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) related to any and all health benefits due to me and my dependents. I authorize release of any information relating to this claim.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

_____ _____

Signature of Patient or Insured Today's Date