

Insurance Authorization

Ravenna Family Dentistry

12374 Stafford Street

Ravenna, MI 49451

Signature on File

- I authorize use of this form on all insurance submissions
- I authorize release of information to all of my insurance carriers
- I understand that I am responsible for my bill
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers
- I authorize payment directly to my doctor
- I permit a copy of this authorization to be used in place of the original

Name: _____

Please Print

Signature: _____ **Date:** _____