Riverview Dentistry

SIGNATURE ON FILE

11916 Boyette Road
Riverview, FL 33569
P: 813.343.8848

PATIENT'S NAME (PRINT):

FIRST	M.I.	LAST

I hereby authorize payment directly to Riverview Dentistry of the dental benefits otherwise payable to me.

SIGNATURE OF INSURED PERSON :

SIGNATURE	DATE

Riverview Dentistry is authorized to provide any insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for my term of coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter.

I know I have the right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

SIGNATURE	DATE