Darlene S. Getz, DDS
PO Box 568
213 N. Paw Paw Street
Coloma, MI 49038
(269) 468-5741

I, (insured's name) ______________________________ hereby authorize the office of Darlene S. Getz, DDS to affix my name to all claims or documents as related to all dental benefits due me and my dependents through my employment/retirement with (insured's employer/retirement company) ____.

____
Today's Date

____
Signature of Patient
(Parent or Guardian)

2 years from date signed
Expiration Date

____
Witnessed By

Authorization for Signature of File
Release of Information

I, (patient)_______________________________ agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. The "Signature on File" will be valid from this date and shall expire in two years. A photocopy of this document may act as an original.

____
Today's Date

____
Signature of Patient
(Parent or Guardian)

2 years from date signed
Expiration Date

____
Witnessed By