



Dental benefit and Information Authorization

Date:

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist.

This authorization shall continue in effect until the undersigned revokes the same.

Signature of patient, parent or guardian _____ Date: _____

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Kevin Lathangue, Dr. Manu Hans and Dr. Bin Kang and authorize payment directly to him.

This authorization shall continue in effect until the undersigned revokes the same.

Signature of Subscriber: _____ Date: _____