

Patient
Name

Last

First

Middle

I Hereby authorize payment directly to Dr. M.Kahveci of the dental benefits otherwise payable to me. (Dentist Name)

Signature (Insured person)

Date

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

Faneuil Hall Dental Associates
Attending D.D.S. Name

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 the term of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter.

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

Signature

Date