



Phone: (914) 941-2200

Chilmark Dental P.C.

15 Pleasantville Rd.
Ossining, NY 10562

Authorization for Signature on File Release of Information/Financial Responsibility/Authorization for Payment

I, _____ and/or _____
Name of Patient (Parent or Guardian if Minor) Name of Insured

hereby authorize the office of Chilmark Dental P.C. to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and material 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 the claim

This "Authorization" will be valid from this date forward and shall expire if my employment with the above company terminates.

A photocopy of this document may act as an original.

Signature of Insured

Witnessed by

Signature of Patient (Parent or Guardian if Minor)

Today's Date _____