Signature on File

Policy Holder________________________________

I authorize the use of this form on all of my insurance submissions. I also authorize release of information to all of my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance company. I authorize payment directly to my doctor. I permit a copy of this authorization to be used in place of the original. My signature also applies to the dependents listed below.

Dependent's Name	Date of Birth

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Signature **Date**