AUTHORIZATION TO RELEASE INFORMATION

I, ____________________________________ authorize ______________________________, to

Patient Name Insurance Co.

release benefit and/or claim information to ____ and/or Dental Systems, Inc. This consent is effective until such date as I can cancel this consent in writing. I understand that information obtained as a result of this consent may be used after the cancelation date. This information will be used only for the purpose it is intended.

______________________________________ ______________________

Patient Signature Date Signed