

\_\_\_\_\_  
PATIENT NUMBER

PATIENT'S NAME \_\_\_\_\_  
Last First Initial

I hereby authorize payment directly to \_\_\_\_\_  
of the dental benefits otherwise payable to me.

Dr. Rick Liftig  
10 Princeton Street  
West Hartford, CT 06110  
(DENTIST'S NAME)

\_\_\_\_\_  
SIGNATURE (INSURED PERSON)

\_\_\_\_\_  
DATE

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

\_\_\_\_\_

\_\_\_\_\_

Dr. Rick Liftig  
10 Princeton Street  
West Hartford, CT 06110

\_\_\_\_\_  
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 a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

\_\_\_\_\_  
PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

**SIGNATURE ON FILE**