

**IN THE MATTER OF THE  
PERSONAL INFORMATION PROTECTION AND  
ELECTRONIC DOCUMENTS ACT**

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To: \_\_\_\_\_  
*Insurance Company*

**PATIENT AUTHORIZATION  
FOR RELEASE OF PATIENT INFORMATION TO DENTIST**

I, \_\_\_\_\_, authorize  
*patient name*  
release to Dr. \_\_\_\_\_ information  
contained in pre-authorizations and claims submitted electronically and otherwise. I  
also authorize release of information pertaining to my dental coverage and benefits.

The authorization shall continue in effect until the undersigned revokes the same for  
Group Plan No. \_\_\_\_\_, I.D. No. \_\_\_\_\_.

\_\_\_\_\_  
*Signature: patient, parent or guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print Name: patient, parent or guardian*