DENTAL TECHNOLOGY CENTER
OF HAWAII

1314 S. King St., Suite 724 Honolulu, Hi 96814
O: 291-2254 F: 596.2384 E: dtcofhawaii@outlook.com

Authorization to Release Information

I hereby authorize *Dental Technology Center of Hawaii* to:

(1) release any information necessary to insurance carriers regarding my illness and treatments;

(2) Process insurance claims generated during treatment; and

(3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing.

I have requested medical services from: *Dental Technology Center of Hawaii* on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for all charges incurred in the course of the treatment authorized.

I hereby affirm that any payment made to me by my Insurance Carrier will be immediately transferred to *Dental Technology Center of Hawaii* upon receipt for services rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement EOB or Check.

A photocopy of this assignment is to be considered as valid as the original.

_____

Patient/Responsible Party Signature Date

_____

Witness Signature Date