Thomas J. Herrick, D.D.S.
5330 Corporate Center Loop SE
Lacey, WA 98503
360-456-3166

Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment

I hereby authorize the office of Thomas J. Herrick, D.D.S. to affix my name to any and all claims or documents as related to any health benefits due to my dependants or myself. I hereby authorize payment of dental benefits otherwise payable to me, directly to Dr. Herrick's office. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

*A photocopy of this document may act as an original.

_____ _____

Signature of Insured, Patient, or Guardian if Minor Today's Date

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Witnessed By—Office Signature Only