Name_____

Authorization

I hereby authorize Dr. Steven M. Levy to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and health history are correct to the best of my knowledge. I grant to this practice the right to release my records/health history and information about my dental treatment to a third party payer and/or other health professional by any method including electronic transfer. Patient portion is due on or before date of service. If your insurance does not pay for any reason you are responsible.

Signature_____

Date_____