

INSURANCE AUTHORIZATION

CRAIG R CAMERON, DDS, PLC

12374 STAFFORD STREET

RAVENNA, MI 49451

(231) 853-6618

SIGNATURE ON FILE

- I authorize use of this form on all insurance submissions.
- I authorize release of information to all my insurance carriers.
- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Name: _____

Please Print

Signature: _____ Date: _____