AUTHORIZATION
STATEMENT FOR ADULT

PATIENT'S NAME: _____

I HEREBY AUTHORIZE **DR. KLIFFORD T. KAPUS** TO PROVIDE ORTHODONTIC TREATMENT FOR MYSELF AND FURTHER AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL/OR AND DENTAL INFORMATION TO MY INSURANCE CARRIER(S) INCLUDING REDISCLOSURE BY MY CARRIER IF INSURANCE IS UNDER A GROUP OR SIMILAR POLICY FOR PURPOSES OF CLAIMS ADMINISTRATION, EVALUATION, UTILIZATION, REVIEW AND FINANCIAL AUDIT. AUTHORIZATION IS ALSO GRANTED FOR THE RELEASE OF SUCH INFORMATION TO THE CALIFORNIA DENTAL ASSOCIATION OR ANY COMPONENT THEROF FOR THE PURPOSES OF PEER REVIEW CONCERNING QUALITY OF CARE PROVIDED, THE NECESSITY OF SUCH CARE, ECONOMIC JUSTIFICATION OF CHARGES OR OTHER REASONS DEEMED APPROPRIATE BY THE ASSOCIATION.

THIS AUTHORIZATION REMAINS VALID AND EFFECTIVE FROM THE DATE OF SIGNING UNTIL REVOKED IN WRITING.

I HAVE READ AND UNDERSTAND THIS AUTHORIZATION AND HAVE BEEN GIVEN A COPY FOR MY RECORDS.

SIGNED: _____ DATE: _____

(PATIENT AUTHORIZING TREATMENT)

PRINT NAME: _____