



**CONSENT TO THE TRANSMISSION OF INFORMATION
TO DENTAL INSURANCE COMPANIES**

I, the undersigned, _____, authorize the Dental Clinic Roy to transmit my relevant personal information (e.g., name, date of birth, diagnosis, treatment plan, x-rays, estimated costs, etc.) to my dental insurance company for the purpose of obtaining a treatment estimate or preauthorization.

I understand that this information is necessary to facilitate the reimbursement of dental care or the preapproval of certain treatments.

I acknowledge that this authorization is voluntary and that I may withdraw it at any time upon written request.

Date : ____ / ____ / ____ Patient's signature : _____

Parent or guardian's signature, if patient is a minor.

Name of parent/guardian : _____

Date : ____ / ____ / ____ Parent or guardian's signature : _____

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