Paul E. Coggins
DDS, MPH

Patient's name _____
Last First Middle Initial

I hereby authorize payment directly to **Paul E. Coggins, DDS, MPH, PA** of dental benefits otherwise payable to me.

_____ _____
Insured person's signature Date

Signature is valid for two years from the date above unless revoked by me at an earlier date.

Paul E. Coggins, DDS, MPH, PA is authorized to provide any insurance company(s), claim administrator(s), and consulting health care professional, information concerning health care advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contact, in force on this date only, or for two years, whichever comes first.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____ _____
Patient or authorized person's signature Date

SIGNATURE ON FILE