



Authorization For Signature On File

I _____ hereby authorize the office of Michael I. Rouff, D.M.D., N.M.D. to affix my name to any and all claims or documents as related to any and all dental benefits due. I authorize the release of any information relating to my dental claims. I understand that I am responsible for all costs of dental treatment. I authorize benefit payments directly to go to the Dental Health and Wellness Center, the office of Michael I. Rouff, D.M.D., N.M.D.

This "Signature On File" will be valid from this date and shall expire in one year.

A photocopy of this document may act as an original.

Signature of Insured: _____

Date: _____

Witnessed by: _____

Date: _____