

**Signature on file**

**I hereby authorize that as long as M. C. Harrison DDS keeps this document on file, she may use it to represent my consent in filing for insurance payment of any dental procedures she has performed for myself or my dependents.**

**Payment of the group insurance benefits otherwise payable to me will be made directly to M.C. Harrison D.D.S.**

**I authorize the release of any information relating to these claims.**

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**Signature of Insured Person**

**Date**