



Anna M. Munné, D.D.S., P.A.

Periodontics • Endodontics • Implants

**RELEASING CONFIDENTIAL INFORMATION TO YOUR INSURANCE
COMPANY**

Date _____

I, _____, authorize Anna M. Munné, D.D.S., P.A., to release confidential information regarding my medical and dental records to my insurance carrier for the purpose of obtaining partial reimbursement from my insurance benefits.

Print Patient's Name

Patients Signature

Parent or Guardian

Witness