



DUNDAS & MAIN
D E N T I S T R Y

EDI Signature

**Dundas and Main Dentistry
85 Dundas Street North
Cambridge ON**

I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically.

This authorization shall continue in effect until the undersigned revokes the same.

(Signature of Patient, Parent or Guardian)

(Date)

(Printed Name)