



**ROBERT A. WEINTRAUB, D.M.D.  
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**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize the above named dentist(s) to provide any insurance company(s), Claim administrator(s), and consulting health care professional(s) information concerning health care, advice, treatment, or supplies provided.

This information will be used exclusively for the purpose of evaluating and administering claim for benefits.

\_\_\_\_\_  
Patient or Authorized Guardian's Signature

\_\_\_\_\_  
Date