



Dr. Garnet Jack DMD
Authorization for Signature

Release Of Information/Financial Responsibility/ Authorization For Payment

I (name of patient)

_____ and/or

(name of insured) _____

herby authorize Universal Dental to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with (name of employer) _____ . I

herby authorize payment of dental benefits otherwise payable to me directly to the office above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

To the extent permitted under applicable law, I authorize release of any information relating to the claims.

Signature of Patient (Parent or Guardian if minor)

Signature of Insured

Today's Date