AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize J-town Comprehensive Dental Center, Dr. Christina Beckham DMD, to release to health care service plans, insurance companies, self-insurers, or their representative, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claims for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective until I give further notice.

I know that I have the right to receive a copy of this authorization if requested.

I certify that I have read and fully understand the above Consent and Financial policy for the performance of dental treatment and procedures and that the explanations referred to have been made. If I am unclear on any of the before mentioned statements, it is my right to ask for clarification.

_____
Name of patient (Please Print)

_____ _____
Signature Date

_____ _____
Relationship to patient – parent/guardian/committee Witness