SIGNATURE AUTHORIZATION FORM

I have reviewed the following treatment plan. I authorize the release of any information relative to this claim.

_____	_____	_____
Print Name	**Sign Name**	**Date**

Patient (or guardian, if patient is a minor) please print and sign your name.

I hereby authorize payment of my group insurance benefits, otherwise payable to me, to Dr. T. Scott Jenkins. (This authorization applies only to non-participating dentists. Claim payments are mailed directly to participating dentists).

_____	_____	_____
Print Name	**Sign Name**	**Date**

Insured policy holder, please print and sign your name.