Just for Kids
Dentistry of Forney
Dentistry for Infants, Children and Teenagers
Board Certified Specialists in Pediatric Dentistry

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AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF DENTAL BENEFITS

I, _____ (patient / guardian name) authorize

_____ (insurance company), to release benefit and / or

claim information to Just For Kids Dentistry of Forney and / or Dental Systems, Inc.

I also authorize Just For Kids Dentistry of Forney to electronically file any insurance claims generated for reimbursement of dental procedures.

I authorize payment directly to Just For Kids Dentistry of Forney of the group insurance benefits otherwise payable to me.

This consent is effective until such date as I can cancel this consent in writing. I understand that information obtained as a result of this consent may be used after the cancellation date.

This information will be used only for the purpose it is intended.

_____ _____

Signed Parent or Legal Guardian Date