Garden Oaks Dental

SIGNATURE ON FILE

Patients Name: _____

(Last) (First) (Initial)

I hereby authorize payments directly to: Zaman Dental, P.A.

(Signature of insured or Authorized Person)

Signature is valid for two years from the above date, unless revoked by the insured person at an earlier date

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DR. ZAMAN (ZAMAN DENTAL, PA) is authorized to provide your insurance company, claim administrators and consulting health care professionals, information concerning health care advice and treatment provided. The information will be used for the purpose of evaluating and administering claims for benefits.

This authorization form is valid for the term of the policy coverage or contract in force on this day, or for two years whichever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is a valid original.

(Signature of the Insured or Authorized Person) (Date)