AUTHORIZATON FOR SIGNATURE ON FILE

Release of Information/Financial Responsibility/Authorization for Payment

I hereby authorize my dentist, Robert W. Yaskin, D.M.D., and my dentist's staff, to act on my behalf in connection with a claim for any dental benefit or an appeal of any adverse dental benefit determination that I personally could pursue in my own name. In furtherance of this authorization, I also expressly authorize my dentist to seek advice from and to enlist the assistance of the New Jersey Dental Association, its legal counsel and other pertinent employees, and without obtaining a business associate agreement, to convey to them any information including protected health information, pertinent to the claim or the appeal. This authorization is continuing and will remain in effect until revoked in writing by me.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above.

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 claim.

Signature: ______________________________________

Print Name: ____________________________________

Today's Date: __________________________________