

JEFFREY A. BRACKETT, D.M.D., LLC

SPECIALIST IN PERIODONTICS

OAK HILL PROFESSIONAL CENTER

243 U.S. ROUTE #1, SUITE 1

SCARBOROUGH, MAINE 04074

TELEPHONE (207) 883-1248

YOUR SIGNATURE IS NECESSARY FOR US TO

- 1. PROCESS ALL INSURANCE CLAIMS,**
- 2. TO ENSURE PAYMENT FOR SERVICES RENDERED,**
- 3. TO RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES, AND**
- 4. TO RELEASE INFORMATION TO OTHER MEDICAL/DENTAL PROVIDERS, WHEN NECESSARY, FOR YOUR TREATMENT.**

I authorized the release of all medical information necessary to process my claims and I authorized the release of this same information, when necessary, to other providers rendering medical/dental care. I assign to medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Jeffrey A. Brackett. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as be valid as the original.

Patient _____ Responsible Party _____

Witness _____ Date _____