George S. Mayweather, D.D.S.

Release of information related to examination or treatment and assignment of benefits.

The undersigned patient, in requesting examination and/or treatment after this date, authorizes the release of all information (including x-rays, photos and models) relating to said examination or treatment to the health service plans, clinician accepting responsibility of treatment and insurance companies named below.

I authorize the release of such information to any peer review committee or the state or local dental associations which may request it.

1. _____

name of insurance company (primary carrier)

2. _____

name of insurance company (secondary carrier)

I hereby authorize payment to be made directly to the dentist named above of the insurance benefits otherwise payable to me, but not to exceed his actual charges for the covered services. I understand that I am financially responsible for any charges not covered by my insurance benefits. A photocopy of this release and assignment of benefits shall be considered as valid as the original.

Executed at _____, Calif.

Date _____

_____

Patient signature

_____

Responsible party signature