JAMES P. KENNEDY, D.D.S., P.C.

2784 N. Decatur Road
Suite 110
Decatur, Ga. 30033
404-299-1984

I hereby authorize payment directly to James P. Kennedy, D.D.S. of the dental benefits otherwise payable to me.
I also understand that I am financially responsible for any charges not covered by my authorization.

_____
Signed (insured Person)

_____
Date

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

You (James P. Kennedy, D.D.S.) are authorized to provide any insurance company(s), claim administrator(s) and consulting health professionals, information concerning health information will be used for the purposes of evaluating and administrating claims for benefits.

This authorization is valid for the term or coverage of the policy or contract, in force on the date only, or for two years, which ever is shorter.

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

_____ _____
Patient or Authorized Person's Signature Date