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FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION - LIFETIME

I certify that the information given to me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for Physician Services to the physician or organization furnishing the services or authorized such physicians or organizations to submit a claim to Medicare for payment to me.

Patient Signature _____ Date _____