encore
UROLOGY

Lifetime Authorization

Today's Date: _____

I certify that the information given by me in applying for payment under Title XVII 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 request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit to Medicare for payment.

I request that this authorization also apply to all other insurance.

Signature: _____

Title or Relationship: _____

If signed by other than the Beneficiary, state the reason the patient was unable to sign: _____

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