LIFETIME AUTHORIZATION FOR PHYSICIAN SERVICES:

MEDICARE:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Blue Ridge Ear, Nose, Throat & Plastic Surgery, Inc., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable related services.

_____
Patient Medicare Beneficiary Signature

_____
Date

MEDICARE EXTENDED INSURANCE:

I request that payment of authorized Medigap benefits be made on my behalf to Blue Ridge Ear, Nose, Throat & Plastic Surgery, Inc., for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.

_____
Patient Signature

_____
Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the Privacy Notice. (Version _____)

_____
Patient or Personal Representative's Signature

_____
Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

_____