

Medical Release Authorization for Claims

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (supplier)_____ for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____ **Date:** _____

Patient Full Name: _____

Please Print