

LIFETIME MEDICARE AUTHORIZATION

PATIENT'S NAME _____

PATIENT'S MEDICARE NO _____

AUTHORIZATION PERIOD: FROM _____ TO _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: **Dr. Erling Larson, Dr. David Pratt, Dr. William Davidson, Dr. Richard Weyman, Dr. Young Huh, and Dr. Anjana Kumar - Gastroenterology Associates P.C.** for any services furnished to me by the physician/supplier during the effective period of this authorization and I authorize the provider named above to release information to the Social Security Administration or its intermediaries or carriers, any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

PATIENT'S SIGNATURE

DATE