Patient Name: _____DOB:_____

Acct# _____Dr.Initials:_____

AUTHORIZATION TO RELEASE INFORMATION /PAYMENT

I request that payment of authorized Medicare benefits be made either to me or on behalf of St.Louis Medical Clinic, P.C. for any services furnished me by that provider. 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 of the benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

I hereby authorize the physician to release information related to this claim. I further authorize payment directly to the physician of benefits due to me for his services as described herein. I understand I am financially responsible for charges not covered by this authorization. Payment is due and payable within 30 days of billing date.

Name of new insurance:_____

Signature:_____Date:_____