

PANAMA CITY UROLOGICAL CENTER

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**RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS / LIFETIME SIGNATURE
AUTHORIZATION FOR MEDICARE B AND COMMERCIAL INSURANCES**

I _____ authorize PANAMA CITY UROLOGICAL CENTER, or any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers for Medicare claims or to my insurance company or its representatives, any information needed concerning the examination or treatment rendered to me that is necessary to process an insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits be paid directly to the Center who accepts assignment. This assignment will be a lifetime authorization.

Health Insurance Policy Number

Patients Signature

Reason if patient unable to sign

Signature if by other than the patient

Date Signed

Patients Name (please print)

Patients Social Security Number or Date of Birth