

Patient Name _____

Chart # _____

Medicare/Commercial MC ID# _____

I request that payment of authorized Medicare benefits be made either to me or to **Powhatan Family Physicians, Ltd** , for any service/s furnished me. I also authorize any holder of medical or other information about me, to release to the Centers for Medicare and Medicaid Services [*formally Health Care Financing Administration (HCFA)*] or its agents, any information needed to determine these benefits or the benefits payable for related services.

Patient Signature

Date

Witnessed by